



HIV CASE MANAGEMENT HANDBOOK

(STANDARDS AND GUIDELINES)



RYAN WHITE PROGRAM

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CASE MANAGEMENT STANDARDS AND GUIDELINES

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INTRODUCTION

The HIV/AIDS Case Management Standards and Guidelines Manual provides standardized and systematic procedures for HIV/AIDS Case Managers when case managing clients participating in the Mecklenburg County Health Department Ryan White Part A Program. It is hoped that these Standards and Guidelines will promote seamless delivery of case management services to clients and encourage standardization of case management services throughout the Charlotte-Concord-Gastonia-Rock Hill, SC Transitional Grant Area (TGA).

Many clients cannot access or interpret the health care delivery system to their best advantage. Case management is an authorized service which helps clients and their families make informed decisions based on the client's needs, abilities, resources and personal preferences. Case management services, when performed correctly, facilitates personalized care in an otherwise impersonal system of care.

The many different systems of care have increased the need for case management coordination to avoid unnecessary duplicative services for persons with HIV/AIDS. Even with the changes over the years, the objectives of case management have remained the same:

- To increase the quality of care and quality of life for persons with HIV/AIDS
- To improve service coordination, access, and delivery
- To reduce costs of care through coordinated services which keep persons with HIV and AIDS out of the hospital
- To provide client advocacy and crisis intervention services

The HIV/AIDS Case Management Standards and Guidelines have attempted to address the significant changes in case management across the TGA to provide standardized case management services for North Carolina's HIV/AIDS population.

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Department of Health HIV/AIDS Program Coordinators

Bureau of HIV/AIDS staff

SECTION 1: ADMINISTRATIVE GUIDELINES

This section provides the Case Management Standards and Guidelines for the statutory, personnel, staff training, confidentiality and other administrative requirements for case managers and case management providers. These guidelines embody the federal requirements relating to case management services whether medical case management or regular case management.

1-1 MEDICAL CASE MANAGEMENT DEFINED

Medical case management services are defined in the Ryan White Treatment Extension Act of 2009 (formerly the Ryan White Treatment Modernization Act of 2006). This definition delineates the allowable case management services funded by the Health Resources and Services Administration and the minimum key activities provided to eligible clients requesting and accessing case management services. This definition provides the framework for case management services which is defined as:

A range of client-centered services that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management that prevents unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.

Key activities include:

- *initial comprehensive assessment of the client's needs and personal support systems*
- *development of a comprehensive, individualized service plan*
- *coordination of the services required to implement the plan*
- *client monitoring to assess the efficacy of the plan*
- *Periodic re-evaluation and revision of the plan as necessary over the life of the client: This may include client-specific advocacy and/or review of utilization of services*

Providing specific services such as housing assistance or transportation are not case management, but identifying need for housing assistance, transportation, or other services, and arranging to have that assistance provided is case management.

Not all clients need to be case managed, and clients who are capable and willing to case manage themselves should be encouraged to do so.

<p>Standard 1: The Ryan White Treatment Modernization Act case management definition describes the required case management key activities that shall be provided to eligible clients requesting and accessing case management services.</p>

1-2 AUTHORITY AND REGULATION

The case management services as described in this document are provided under the authority and oversight of the patient care programs administered by the Mecklenburg County Health Department. Other laws and regulations affecting case management include the following:

Ryan White HIV/AIDS Treatment Modernization Act of 2006

This federal legislation represents the largest dollar investment made by the federal government to date specifically for the provision of services to low income persons living with HIV disease. The Ryan White HIV/AIDS Treatment Modernization Act is intended to help communities and states increase the availability of primary health care and support services, to reduce more costly inpatient care, increase access to care for underserved populations and improve the quality of life of those affected by the epidemic.

Mecklenburg County Health Department, as the grantee of the Ryan White Part A Program, is responsible and accountable for oversight of the program. The Department enters into contractual agreements with lead/fiscal agencies to ensure the provision of case management and other allowable services to eligible individuals in compliance with state and federal requirements under the authority of the following:

1-3 CASE MANAGEMENT PERSONNEL

All personnel providing case management services must be qualified. Case management providers must staff their agency with qualified individuals at the case manager, supervisor, support staff and administrative levels.

1-4 CASE MANAGER QUALIFICATIONS

An HIV/AIDS case manager must be able to work with clients and develop a supportive relationship, enable clients to make the best choices for their well-being, and facilitate access to and use of available services. In order to be effective in their work, case managers should have certain skills and a certain level of compassion and caring for others. At a minimum, all case managers hired by case management providers must be able to demonstrate through administrative and communication skills the ability to conduct a comprehensive client assessment, develop a service plan, provide service coordination with other agencies and complete documentation.

Case managers hired by the case management provider must have at least the following staff qualifications:

- An individual can have a bachelor's degree in a social science area or be a registered nurse with at least one year of case management experience
- An individual with a master's degree can substitute their degree for one year of case management experience
- An individual with a bachelor's degree not in a social science must have at least six months in direct case management experience
- An individual may substitute applicable experience on a year-to-year basis for the required education with an exception from the Grantee's office

1-5 SUPERVISOR QUALIFICATIONS

Case managers must have an immediate supervisor for guidance, direction and support in providing case management services to persons with disease and skilled in directing and evaluating the scope and quality of case management services. Supervisors must meet the case manager qualifications and the following:

- Supervisors must have related experience in providing case management services to persons with HIV disease or other chronic illness. Be experienced with or know the local community resources which will be utilized by the case manager. Have time to routinely review and approve case management records to facilitate the case manager's duties. Provide routine support and supervision to the case manager
- Provide an interim case management supervisor when on leave or a position is vacant

Where this is not practical, the supervisor should be an individual responsible for overseeing other employees and programs providing direct services to clients. Examples of such management staff include public health nursing supervisors and clinical social work supervisors. Case management providers should develop promotional and career ladder opportunities to retain their case managers.

1-6 SUPPORT STAFF

Case management requires extensive documentation of complex information for clients, referral resources, funding, and ongoing reporting. In order to maximize the amount of time the case managers have working directly with client needs and services, agency support staff, volunteers, and ancillary equipment such as computers should be provided.

Case management agencies should consider staff other than case managers to be trained to complete the eligibility determination process (**Section 2**) to allow case managers more time for direct client involvement.

Standard 2: Case managers, supervisors and support staff must meet the personnel qualifications established in this section of the Case Management Standards and Guidelines.

1-7 CASE MANAGER TRAINING

All staff should be provided opportunities for training with all aspects of HIV/AIDS to better understand the needs of the clients served. At a minimum, case managers must participate in the following as applicable:

- An initial orientation to the HIV/AIDS Case Management Standards and Guidelines
- Introduction to applicable local, state and federal referral resources and local programs within 60 days of being hired
- Review of the intake/eligibility process (Section 2)
- Basic and advanced information on HIV disease

- Applicable HIV/AIDS case management training provided by the Department of Health and State of North Carolina
- Completion of the 500 course and the HIV/AIDS 501 Prevention Counseling, Testing, and Referral course. An HIV/AIDS 501 annual update is also necessary if the case manager is performing HIV counseling and testing as a part of their job duties.

The HIV/AIDS 500 and the 501 courses are recommended for case managers who do not perform HIV counseling and testing as a part of their job duties.

In addition case management staff should be provided routine and consistent in-house training related to agency policy and practices and case management skills. Case managers should have access to community training deemed necessary for professional skill or service development. Staff training needs should be assessed through routine supervision, annual staff performance evaluations, and new program or resource development.

Standard 3: Case management agencies must provide initial orientation and training for new case management staff and ensure participation in department sponsored case management training.

1-8 CLIENT FILE ORGANIZATION

Each client file must be neatly maintained and organized. All pertinent client interactions, documentation and required reports must be included in the record. Memory recall is not reliable especially when weeks have elapsed since the date a contact was made. Field notebooks or other methods of note taking must be kept current and incorporated into a hard copy of the client's file especially when notes are determined to be important for future activities relating to the client. A hard copy of the client's current record must be available and accessible at all times.

The client's case record at a minimum must be labeled within the file in the following order:

- a. Intake/Eligibility Determination
- b. Initial Comprehensive Assessment
- c. Individualized Service Plan/Service
- d. Monitoring and Service Plan Revision
- e. Client Termination or Discharge

1-9 EMPLOYEE ADHERENCES TO CLIENT CONFIDENTIALITY

All case management providers and staff with access to client information must receive routine training on confidentiality, the proper exchange of information and required consent. A Confidentiality and Security Statement of Understanding must be signed by all employees of the case management provider (Attachment A). Signed copies of agreements should be filed in each employee's personnel file. Procedures to ensure the protection and confidentiality of all confidential matters shall be consistent with

the Department of Health's information security policies, protocols and procedures.

It is the responsibility of all case management staff to take prudent and reasonable steps to protect confidential information. All written and verbal communications pertaining to individual clients shall be maintained in strict confidentiality. Other factors:

- Case managers must be familiar with the agency's **Authorization for Release of Medical Information Form** and applicable forms which must be signed by the client prior to the exchange of any verbal or written information about the individual/family to other providers. Authorization for release of medical information is valid until the client revokes the authorization. It is not required, but recommended that this authorization be renewed annually. Case managers can list multiple medical providers per form to eliminate the need for client's to sign numerous copies of the form. The client should put his/her initials beside each service listed on the form. It is suggested using a separate release form for all non-health related providers that need access to certain client information. Current Confidentiality and Security is maintained in employee personnel files. Access to confidential information is limited to persons with the need to know. Documentation of individuals with need to know is incorporated in the Department of Health's information security, policies, protocols and procedures.
- Confidential information shall be protected from unauthorized individuals. Both hard copy and electronic information shall be maintained and stored in areas that limit access.
- Unauthorized persons shall be escorted and not left unattended in areas where confidential or sensitive information is maintained. All telephone calls in which confidential information is discussed must be made from an area that ensures confidentiality is maintained. Cell phones are not considered secure and should not be used for confidential phone calls.

1-10 WORK SPACE

Case management staff should be provided with office space which allows them to conduct client business in a timely and confidential manner. Office space should allow case managers to interview clients without other clients or staff present. If private office space with a door is not available, the case management provider must ensure that other staff or agency clients do not have access to confidential communications.

1-11 CLIENT FILE STORAGE

Case management providers shall provide an appropriate storage system for client files (hard copy). The system should include, at a minimum, files which securely hold and organize materials and which are in locked files located in a room or facility securely locked from public access.

The case management provider and case manager must maintain confidentiality of all data, files, and records including client records related to the services; and shall comply with state and federal laws, including, but not limited to, HRSA and HIPAA policies, procedures and standards, and N.C. General Statutes 130-A - Confidentiality of Records. Procedures to ensure the protection and confidentiality of all confidential matters must be consistent with the above mentioned authorities.

1-12 CLIENT FILE RETENTION

The case management record retention must follow the N.C. Department of Cultural Resources Division of Archives and History, Records Management storage and disposition procedures as mandated in N.C. General Statutes 121 and 132.

The client file retention schedule for case management providers contracted with Mecklenburg County Health Department is five years from the date of termination of a case management provider contract with the Department of Health. Upon completion or termination of the contract and at the request of the department, the case management provider will cooperate with the department to facilitate the duplication and transfer of any said records or documents during the required retention period. This retention schedule applies to case management files retained by all case managers.

In the event that a client dies or stops receiving case management services, the client file is retained at the agency for the minimum five years before disposing of the said records. Shredding of documents is the preferable method of disposal.

1-13 ELECTRONIC FILES AND COMPUTERS

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality and protect the client's right to privacy.

Electronic mail must never be used to transmit unencrypted confidential information. Other electronic transmissions of confidential information must be safeguarded consistent with current departmental policies and protocols. Both hard copy and electronic information shall be maintained and stored in areas that limit access.

- Computer monitors shall be placed to prevent unauthorized viewing
- Computer systems with modems must adhere to the provisions in Security Policy 16
- All computers including laptops that access or store confidential information must be password protected and the data must be encrypted in accordance with departmental policies, protocols and procedures
- Laptops can be used for storing or accessing information with client identifiers if they adhere to the specific requirements
- Laptops containing confidential information must never be kept at an employee's home and must be returned to the secured area at the end of the working day
- HIV/AIDS information cannot be faxed except in the case of a medical emergency, or with the written informed consent of the client (Attachment C)

Standard 4: Case management providers and staff must adhere to all requirements, policies, and protocols relating to client confidentiality at all times.
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1-14 GRIEVANCE PROCEDURES

Case management providers must establish and follow a system of internal agency procedures through which clients may present grievances if services are reduced, suspended, denied, or terminated; or if a client is dissatisfied with the way services are provided. New clients are to be informed of the grievance policies and procedures during the first contact. Clients will be reminded of the grievance policy whenever a problem is identified that may result in a grievance.

1-15 CLIENT'S RIGHTS AND RESPONSIBILITIES

All clients have the right to be treated respectfully by case management staff. Clients also have a mutual responsibility to work cooperatively and agreeably with case management staff. Clients are provided a

copy of their rights and responsibilities once eligible for services.

The Client's Rights and Responsibilities Policy should:

- Ensure that the client's decisions and needs drive the case management process
- Ensure a fair process of case review if the client believes he/she has been mistreated, poorly serviced or wrongly discharged from case management services
- Clarify the client's responsibilities which help facilitate communication and service delivery

Case management agencies must develop and post the Client's Rights and Responsibilities agreement in a conspicuous location in the agency. The client must be provided a copy this agreement at the time client eligibility has been determined. Eligible clients are provided a copy to sign once enrolled in a case management agency and receiving services (Attachment E).

Standard 5: Clients have the right to expect fair treatment and services by case management staff and it is the responsibility of the case management provider to ensure this occurs.

SECTION 2: INTAKE AND ELIGIBILITY DETERMINATION

This section provides the intake and eligibility requirements and the standardized **Intake/Eligibility Form (a-f)** for staff (who may or may not be case managers) to obtain and determine a person's eligibility for Ryan White Part A services.

The HIV/AIDS patient care services provided by the department are not entitlement programs. The Ryan White Program and other programs provides limited patient care funds to target low-income individuals who are in need of financial support based on the Federal Poverty Guidelines used for HIV/AIDS related medical and support services. The following process should ensure that only low income and eligible individuals receive the necessary services depending on the availability of funds.

2-1 GENERAL INFORMATION

The personal contact and client eligibility information obtained during the intake/eligibility process is not to be confused with the initial comprehensive assessment which is conducted by a qualified case manager as one of the key activities of case management services. **(Refer to Section 3.)**

The objectives of the intake and eligibility determination are to:

- Collect basic client information to facilitate client identification and client follow-up
- Inform the client of services available and what the client can expect if eligible for services
- Establish client eligibility for services
- Refer for case management and other services and programs if ineligible

The Guidelines:

1. A client file is established for each individual requesting service.
2. The standardized **Intake/Eligibility Form** is used by all staff (who may or may not be a case manager) conducting this intake/eligibility process. The Personal Contact Information and eligibility requirements listed on the form include:
 - a. Personal contact information
 - b. Proof of HIV status
 - c. Screening for Medicaid and other service and programs
 - d. Client financial assessment
 - e. North Carolina resident
 - f. Willingness to provide appropriate information
3. All of the standards and guidelines established in this section for eligibility determination must be completed and documented as stated.
4. The intake/eligibility process must be initiated within 3 working days of initial contact with the agency conducting the intake/eligibility process.

Standard 6: The initial intake and eligibility process must be initiated within 3 working days of the client's initial contact with the agency to request services.

2-2 ELIGIBILITY REQUIREMENTS

The standards and guidelines for the five (5) eligibility and documentation requirements to receive HIV/AIDS medical and support services (including case management services) provided by the Ryan White Part A Program must be documented on the **Intake/Eligibility Form (Attachment F)** with the appropriate back-up information and included in the file. The five (5) eligibility requirements presented in this section are:

- I. Proof of HIV Status
- II. Screening for Medicaid and Other Services Programs
- III. Client Financial Assessment (Assets and Income)
- IV. North Carolina Resident
- V. Willingness to Provide Appropriate Information

The eligibility determination process must be completed within 30 days of the initial contact with the individual, unless approved by the supervisor and documented in the file. The process may take longer recognizing that during the eligibility process more time may be needed for obtaining documentation and that clients may need additional time to become comfortable revealing and obtaining sensitive information they may not have on hand.

Standard 7: The intake and eligibility process must be completed within 30 days from date of initial contact with the individual, unless justification for an extended time is documented and approved by the supervisor.

I. Proof of HIV Status

A person must have a documented and confirmed HIV infection or AIDS diagnosis to be medically eligible for services. The **Intake/Eligibility Form (b)** with the accompanying documentation is used to validate the HIV status of the person.

The Guidelines:

1. The intake/eligibility staff must obtain a signed **Authorization for Release of Medical Information** and additional consent forms relating to confidentiality from the individual.
2. A laboratory test to document the person's HIV status must include one of the following:
 - A confirmed positive HIV antibody test
 - A positive HIV direct viral test such as PCR or P24 antigen
 - A positive HIV viral culture results

- A detectable HIV viral load or viral resistance test.
- 3. The **Intake/Eligibility Form (b)** is completed as applicable to the person's circumstances and the accompanying documentation is included in the file.

II. Screening for Medicaid/Insurance/Local, State and Federal Programs

There are numerous local, state and federal public benefit and entitlement programs which can serve people in North Carolina with HIV/AIDS. Screening persons for participation and enrollment in these programs is a part of the eligibility requirement. An individual may not be eligible for the Department's services if he or she is already receiving benefits from other programs; especially where payment of services is made by third party payers, including private insurance, prepaid health plans, Medicare, Medicaid (Project AIDS Care), or other state or local entitlement programs.

The services provided by Ryan White Part A Program can only be utilized when no other source of payment exists. Ryan White Part A becomes the payor of last resort. The status of a person's Medicaid eligibility or participation in other local, state and federal entitlement or indigent programs will determine the extent of services which may or may not be available for the person seeking eligibility for services.

The Guidelines:

1. Each person must be screened through the North Carolina Medicaid Management Information System (FMMIS/MEDIFAX) to determine if the individual is eligible or participating in a Medicaid HMO, or is dually eligible for Medicaid and Medicare. The **Intake/ Eligibility Form (c)** is used to document the results.
 - A person who is enrolled and participates in North Carolina's Medicaid Program may not be eligible for the Department's HIV/AIDS services unless the requested services are not offered by the Medicaid Program or are not offered in the quantity required
 - A person who is determined eligible for Ryan White Part A services but is not enrolled in North Carolina's Medicaid Program is referred to the appropriate Medicaid for eligibility determination information
 - A person who is pending enrollment in North Carolina's Medicaid Program, if determined eligible for services provided by the Department after a completed eligibility determination, may be able to access services until Medicaid enrollment is approved with case management services coordination. **(Refer to Section 4)**
2. Each person must be screened for participation in other local, state or federal entitlement or indigent programs and third party payers, including private insurance and prepaid health plans. The **Intake/Eligibility Form (c)** is used to obtain and document this information:
 - Intake/Eligibility staff should be familiar with local, state and federal programs available for individuals with HIV/AIDS for referral and coordination purposes which include but are not limited to those listed on the **Intake/Eligibility Form (c)**
 - A person who is enrolled and participates in another local, state or federal program may not be eligible for the Department's services unless the requested services are not offered or covered by insurance or the specific program; or not offered in the quantity required
 - The **Intake/Eligibility Form (c)** is completed for documentation purposes and included in the file

III. Client Financial Assessment

A person must have an economic (gross) income of less than 300% of the Federal Poverty Level and cash assets less than or equal to \$4,500 for one person or \$5,500 for more than one person to be eligible for services. Most of the clients served are at 100% of the poverty level and will meet this eligibility requirement but every individual must be screened as established in this section.

The Guidelines:

1. The **Intake/Eligibility Form (d), Financial Assessment Worksheet** will be used for determining if the client meets the income and cash assets eligibility requirement and for documentation purposes. Applicable documentation and information is included in the file as required.
2. When determining the family income the following information is provided and is used in conjunction with the worksheet.

If a person lives with a family and can be claimed as a dependent on income taxes, the income of all adult family members (18 and over), unless specified in the income/allowances guidelines, must be included when assessing income eligibility. Family means a household comprised of two or more related persons. The term family also includes:

- One or more eligible persons living with another person or persons who are determined to be important to their care or well-being and the surviving member or members of any family described in this definition
- A person who is not a relative by blood or marriage (e.g., roommate) can be considered a "family" member if they are important to the "care or well-being" of a person with HIV/AIDS
- A live in aide is not considered a family member since they are compensated for providing care to the person with HIV/AIDS

A person who is living with someone who is providing room and board must provide a statement of support from that person for the record.

3. Cash assets which are counted towards eligibility are defined as any easily accessible or liquid cash such as those in:
 - Checking accounts, savings accounts, short term CDs (3 months or less)
 - Non-retirement stock portfolios/mutual funds
 - Equity in rental/vacation property
4. Cash assets, which are not counted for eligibility determination, include:
 - Life insurance policies and retirement/pension accounts
 - Personal residence
 - Personal transportation

5. The income column from the **Financial Assessment Form (A)** plus the family income (B) are each totaled. The poverty level percentage from the Federal Poverty Guidelines that corresponds to the client income and family size is located on the most current Federal Poverty Guidelines. The percentage is documented on the worksheet. The person must be 300% or below the Federal Poverty Guidelines to meet this eligibility requirement. The cash assets are documented for future reference.
6. Persons without income are not required to bring in written documentation of zero income unless there is a substantive reason to believe that they have income. This may include recent cancellation of SSI or Medicaid benefits due to earned income; reporting to other service organizations that they have income while reporting to the AIDS Drug Assistance Program that they have zero income, or similar reasons. A person who is currently unemployed is not required to provide documentation of previous income. However, he or she should be encouraged to file for unemployment compensation benefits. The person signs a self-declaration of no income for documentation purposes.

IV. North Carolina Resident

A person must be living in the state of North Carolina at the time of the eligibility determination. A physical living address (as well as a mailing address if the two are not the same) is sufficient for documentation purposes. This requirement may be modified to fit the circumstances of individuals.

The Guidelines:

1. Persons who do not reside in North Carolina TGA are not eligible for services and should be referred to other appropriate agencies
2. If there is a substantive reason to question a person's actual residency in the state, the person should provide written documentation of residency. The reason for questioning the client's residency must be documented in the file. The documentation of residency requested may include a lease, certificate of domicile, rent receipts, a notarized statement or driver's license
3. Persons who spend the winter in North Carolina and maintain their permanent residence elsewhere should arrange for needed treatment through resources available in their home state
4. Citizenship of the United States is not an eligibility requirement. Persons do not have to document citizenship or immigration status in order to be eligible for services

V. Willingness to Sign and Provide Eligibility Documentation

The **Intake/Eligibility Form (f)** is used to document the person's willingness to sign all forms and provide all appropriate documentation to assist with the eligibility determination process in an expeditious manner.

2-3 DETERMINED ELIGIBLE

If the eligibility requirements have been met, the person is determined eligible for services. The following is completed by the intake eligibility staff:

- The eligible client is provided a written confirmation of his/her eligibility to receive services. There is not a standardized form for this purpose.
- The eligible client is referred to a case management provider of choice if case management services are being requested following the local referral procedures established with case management providers. If the staff completing the eligibility process represents a case management provider the client is still provided a choice of case management agencies in the service area.
- The client's file is copied and transferred to the case management agency within five working days. All required documentation is included in the client's file in an orderly manner.

2-4 DETERMINED INELIGIBLE

Not all persons will be determined eligible for services. The eligibility requirements may not have been met due to HIV-negative serostatus, financial assessment status, failure to provide specific information, or other reasons. The following is completed by the intake/eligibility staff:

- The person is provided a written explanation for his/her ineligibility for services. The reason for the decision is identified in the correspondence. There is not a standardized form for this purpose.
- If the person is not satisfied or does not understand the decision the individual is provided the grievance procedures for recourse. Complainants will have their grievances heard within five working days from receipt of the written complaint.
- The person is referred to other local, state and federal programs which provide related services for HIV/AIDS eligibility determination. **(Refer to Section 7).**

2-5 NO DOCUMENTATION

In cases where no documentation of income is available, the case manager or designated staff determining the eligibility for the person shall document the inquiry and efforts to obtain income documentation. The documentation for a person who states that he or she has had little or no income coming into the household for more than a few months must reflect how food, shelter, and utilities are being managed; such as, if the person lives with someone rent-free, lives in a migrant camp or homeless shelter or receives stamps. Staff should document with specific notes for the file the efforts made to acquire information and why the decision was made to support the client.

2-6 EXCEPTIONS

There may be unusual circumstances which require an exception to the established process. Flexibility to ensure clients in need receive services is sometimes warranted. When in doubt, staff determining the eligibility status of a person must refer all questions to their supervisor and/or the grantee's office for a final decision.

2-7 EMERGENCY SERVICES

Referrals for emergency services should be made available to a person who is HIV positive, is pending eligibility and has an emergency need. Documentation of the circumstances should be included in the file.

SECTION 3: CASE MANAGEMENT ACTIVITIES

This section provides the formal and systematic case management process which is used to assess eligible client needs and link the client to needed services. The definition of case management and the key activities, as described in this section, include the following:

Case management services are a range of client-centered services that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. The key activities of the case management process include:

- Initial comprehensive assessment of the client's needs and personal support systems
- Development of a comprehensive, individualized service plan
- Coordination of the services required to implement the plan
- Client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and revision of the service plan
- Client discharge and transfer

The above case management activities are completed by a qualified case manager.

3-1 INITIAL COMPREHENSIVE ASSESSMENT

The initial comprehensive needs assessment is completed by a qualified case manager after the determination of eligibility for services. Assessing a client's needs is an ongoing process in which enough information has been shared by the client and obtained by the case manager for decisions to be made about needs and services. The client serves as the primary source of information. A good rapport enhances the ability of the case manager to gather sensitive information.

The objectives of the initial comprehensive assessment are to:

- Enroll the client for case management services
- Gather enough client information in order to determine client needs
- Document the needs to develop the client individualized service plan
- Build a trusting relationship with the client.

The client is enrolled with the case management provider following the established agency procedures. The assessment is a face-to-face interaction at a location mutually acceptable to the client and case manager. The assessment can be accomplished through a series of contacts that can occur in a variety of settings, including the case manager's office, inpatient settings, clinics, and home visits. There is no

requirement that assessments be conducted at the client's home. It may not be practical and the client may prefer a location other than home. Home visits are only required if home-based services are being considered. Case managers should always exercise good judgment when completing a home visit and should not risk personal safety if unforeseen circumstances occur.

The Guidelines:

The guidelines for conducting the initial comprehensive assessment include the following:

1. The client's file is established and organized according to the records organization referenced in Section 1-8
2. The intake/eligibility information gathered during the eligibility intake determination process is copied and included in the record in its entirety
3. The client is enrolled with the case management provider following local procedures and forms
4. The case manager will begin the assessment process within 5 days from the client's referral to the case management agency unless approved by the case manager supervisor
5. At a minimum and prior to conducting the Initial Comprehensive Assessment, the client will be advised of the following:
 - Information about the case management provider
 - A description of the health and support services available and the funding limitations as applicable
 - The procedures to access the case manager in case of emergencies, weekends and holidays
 - The case management provider's grievance procedure
 - The client's rights to confidentiality as specified by state statutes and a review of all the authorization to release confidential information forms established during intake
 - Follow-up to any questions from the intake eligibility process
 - A description of key activities and definition of case management and the purpose of the comprehensive client needs assessment
 - Other pertinent information
6. The **Comprehensive Assessment and Assessment Worksheet** are used to assess and document the needs of the client and provide notes for development of the service plan. At a minimum, the following subjects (a-f) must be addressed with the client. Additional topics for discussion under each category are included with the worksheet. A provider agency may use their own assessment form or worksheet but documentation of the following six subjects must be included:
 - Eligibility and participation in other HIV/AIDS programs/services
 - Financial information

- Medical history and current health status
- Client adherence to treatment
- Social information
- Emotional/mental health status

7. The reassessment of client needs is an ongoing process as reflected on the revised service plan.

Standard 8: Qualified case managers must initiate the Initial Comprehensive Assessment within 5 working days from the client referral, document in the required format and include the completed assessment in the client file.

Standard 9: For appropriate clients the Initial Comprehensive Assessment must address coordination with existing adherence programs to ensure client compliance with both medication regimens and medical provider appointments.

3-2 INDIVIDUALIZED SERVICE PLAN

The client individualized service plan is the plan of action written by the case manager who conducted the client's initial comprehensive assessment. The service plan includes the identified service needs, goals, objectives, desired outcomes and realistic time frames. It is developed from the assessment information obtained from the client and the plan is documented on the Client Individualized Service Plan. The development of the individualized service plan is the "bridge" from the client's initial comprehensive assessment to the actual delivery of services.

The objectives of the individualized service plan are to identify and document:

- Client's service needs, goals, objectives and desired outcomes
- The action steps and services necessary to meet the client's need
- Realistic time frames for meeting client goals

The individualized service plan is developed collaboratively by the case manager and client. It includes clearly defined priority areas for needed services and specific actions which must be taken to meet these goals; the agencies and service providers to which clients will be referred and if possible, specific individuals within those agencies who will be contacted; realistic time frames for completing activities; and the identification of potential barriers to service utilization and delivery with proposed solutions to these problems. Unforeseen situations, illnesses, incarcerations, etc. may alter the normal time frames on delivery of services. In addition, factors which could impact the service plan may include client attitude, adherence issues and nonexistent services.

The Guidelines:

1. The case manager will include client participation in developing the service plan
2. The individualized service plan signed by the client and case manager will be completed within **15**

days from the client's referral to the case management agency unless approved by the case manager supervisor. The plan is included in the client's file

3. The case managers should provide the client a choice of service providers if applicable during the development of the plan
4. The service plan is revised as often as necessary but at least every six (6) months. For those clients receiving only information and referral services, the revisions may take place via telephone

Standard 10: The individualized service plan must be completed by qualified case manager and based on the initial comprehensive assessment within 15 days from the client's referral unless an extension is warranted and approved by the supervisor.

3-3 SERVICE COORDINATION

It is the case manager's responsibility to follow through and implement the service plan with the client. Case managers will act as a liaison between clients and other service providers to link clients to needed services. This includes contact with the referral source about the client and advocating for services on behalf of the client if the client is unable to advocate on his/her own behalf.

The objective of service coordination is to:

- Implement the strategies for addressing client needs as established in the service plan
- Coordinate services and referrals
- Advocate for services if client is unable to advocate on his/her own behalf
- Coordinate with other case managers with whom the client may be working (**Section 4**)
- Make arrangements for referrals, authorize services and arrange for payment depending on the local infrastructure

When services are not available or easily accessible for the client, careful consideration by the case manager should be given before providing the services directly (i.e., transportation). The case manager's daily schedule, caseload, location of client's service and other commitments may be negatively impacted.

The Guidelines

1. The case manager will implement the client's service plan
2. The case manager will identify and communicate with other service providers to remove barriers to client linkage to services
3. The case manager will identify and communicate the other case managers with whom the client may be working and cooperatively determine, in collaboration with the client, the person most appropriate to serve as the primary case manager

Standard 11: Case managers must provide the client a choice of service providers if available.

Standard 12: Case managers must be familiar with and keep an updated and comprehensive list of all HIV/AIDS patient care services and resources available in the service area.

3-4 MONITORING AND SERVICE PLAN REVISION

The case manager is responsible for verifying that the client is receiving the expected services and that these services are necessary and meeting the needs of the client. The monitoring of the client's progress in completing the goals identified in the individualized service plan and documentation of the progress is required. Progress notes or field notes should be incorporated into the client's case record. Documentation of the review of the revised service plan does not need to be signed by clients receiving only information and referral services.

The objectives of monitoring and service plan revision are to:

- Ensure that clients are accessing needed referrals and services through appropriate contacts
- Identify and resolve barriers that clients may have in following through with their service plan
- Determine if the client is still in need of case management services
- Reassessing and revising the plan as appropriate
- Providing the appropriate documentation

The case manager will evaluate and monitor the services provided through service provider contact, communication with the client or both. A determination of the client's satisfaction with the services is necessary to ensure that the quality and service delivery is appropriate.

The Guidelines

1. The case manager will determine the extent of the follow-up with the client in order for the client's needs to be addressed. The number and type of client and service provider contact must be ample to address the client's need. Classification as a New, Active or Inactive case should be reviewed to determine the minimum number of contacts. **(Section 5)**
2. The service plan is reevaluated and revised by the case manager to ensure that service provisions are adequate to the current stage of HIV infection and client needs
3. Some clients require only minimal services such as information and referral; thus, may be having only periodic contact with the case manager. Case managers should check in with all clients monthly, unless client signs a waiver stating differently. If, after a maximum of twelve (12) months, the case manager has made repeated attempts to reach a client and is unsuccessful, the client should be discharged from case management services at the agency
4. The service plan is revised as necessary but at a minimum every six months. There may be circumstances beyond the case manager's control which could impact the time frames for service plan revisions and client and provider contact. For example, case manager illness, staff shortages and emergency situations may necessitate the case management agency to shift workload and prioritize case manager time.

Standard 13: Case managers are responsible for verifying the client is receiving the expected services and that these services are necessary and meeting the needs of the client as documented on the individualized service plan.

Standard 14: The number of contacts will vary according to the status of the case as New, Active or Inactive, but case managers must make suitable contact with their clients to address the service needs, goals, objectives and barriers as established in the service plan.

Standard 15: The Individual Service Plan must be revised or updated as necessary, but at least once every six months.

3-5 CLIENT TERMINATION OR DISCHARGE

Client termination or discharge will occur for a number of reasons. A final narrative for inclusion in the client file must be completed with the approval of the supervisor before a case is considered closed.

The objectives of client termination or discharge are to:

- Appropriately close files for clients no longer wanting or needing case management services
- Ensure a smooth transition for a client to other case management agencies
- Accurately track only clients receiving active case management services

The Guidelines:

1. In all discharge or termination circumstances, the case manager must include a final narrative in the client file relating to the circumstances of the client's termination, transition or dismissal.
2. A client may be discharged from case management services for any of the following reasons:
 - Death
 - At the request of the client; client's needs change and he/she would be better served through case management at another provider agency
 - If a client's action put the agency, case manager or other clients at risk
 - If client moves out of the service area; if possible, an attempt should be made to connect client to services in the new service area
 - Other

A. In Cases of Death:

- The case manager should be notified of the client's death by the client's family, significant other, direct care provider, legal guardian, or other designated person approved by the client
- Appropriate referral is made for family and significant others, grief counseling and other support services
- The case manager will notify and verify termination of all funded or arranged services and will facilitate or complete billing requirements
- The case manager will complete the discharge summary for review and

agreement by the case management supervisor

B. In Cases of Client Transfer To Other Case Management Agencies:

- Case managers must acknowledge a client's right to choose and change case managers from different case management providers. The client is not obligated to provide an explanation for changing case management agencies. The reasons can include but are not limited to a move from service areas, transportation or case manager conflict
- Case managers should exercise mutually agreed upon client transfer procedures from one case management agency to another which include:
 - Release requests
 - Billing, notification to service providers
 - Client record transfer
- The client's entire record must be sent to the receiving case management agency within 10 working days from the client's decision to change case management agencies. The expeditious transfer of a client's record from one case management agency to another is critical to the client's continuum of care. Incomplete client records will only hinder the ability of the receiving case management agency for serving the client. All appropriate release of forms must be signed prior to the transfer of any information
- The **complete** record includes the following sections of the file:
 - Intake/Eligibility Determination
 - Initial Comprehensive Assessment
 - Individualized Service Coordination
 - Monitoring and Service Plan Revision
 - Client Termination or Discharge
- Narratives, progress notes, forms, service authorization forms, documentation pertinent to the client's medical and support services; and documentation from other service providers which is essential to the client's plan of care, must also be obtained, copied and sent to the receiving case management agency

Standard 16: The case manager must ensure a copy of the client's record in its entirety is sent to the receiving case management agency within 10 working days from the client's decision to change case management providers.

C. In Cases of Dismissal:

- "Dismissal" shall mean formal action, taken in accordance with the established policies to cease delivering services, close the case record, and bar the client from applying for additional assistance. Dismissal is intended to be permanent. However, with compelling evidence of changes in circumstances and client behavior, the case may be re-opened
- A client may be terminated or dismissed if he or she violates or continues to

violate program requirements in the form of, but not limited to, findings of fraudulent use of assistance, conflict of interest and purposeful omissions, falsifications or misstatements of conditions of occupancy, threats of violence, verbal abuse and harassment, criminal activity, destruction of property, and non-compliance with case manager and client's plan to secure permanent affordable housing

- Action for dismissal of a client should be initiated by the case manager through a written request to the supervisor
- The case manager shall document thorough and persistent attempts to resolve the problems presented by the client. Dismissal of a client can only occur when there is evidence of a persistent and serious problem and repeated efforts to resolve the difficulty have been unsuccessful
- Reasons that constitute sufficient cause for dismissal include, but are not limited to threat of violence, verbal abuse, harassment, persistent non-compliance

Standard 17: All client termination or discharges must include a final narrative in the file relating to the circumstances of the client's termination, transition or dismissal.

SECTION 4: CASE MANAGEMENT COORDINATION

This section provides case management coordination guidelines and addresses the need for case management coordination between other case managers and case management providers within a service area. The client is often participating in more than one HIV/AIDS service program and can have more than one case manager. It is important for case managers and their agencies to coordinate their activities with other case managers and agencies to avoid unnecessary burdens and duplicative services for person with HIV/AIDS.

4-1 GENERAL INFORMATION

Case management coordination includes identification of other case managers with whom the client may be working. The **Intake/Eligibility Form (c)** should be reviewed for the pertinent case manager information obtained during the eligibility process.

Ideally, clients should have only one primary case manager at any one time throughout his/her care. The primary case manager is responsible for overseeing and coordinating care provided through other agencies. The primary case manager is the person designated to conduct the case management key activities as defined in this document. This does not preclude clients from receiving services at other provider locations. A client can access any number of services at any number of service agencies but these are discrete services (such as housing legal assistance, etc.) The client does not receive case management services at every agency to which he/she presents.

Although one primary case manager per client would be the ideal, the reality is that clients may, in fact, be working with several different case managers simultaneously. To eventually achieve a coordinated system of case management services and a system that does not involve duplication of effort on the part of the client or case manager (e.g. going through an intensive assessment process at more than one agency), it is important to work toward a system where a client chooses one primary case manager. To move towards this system, case managers should explain to their clients the rationale behind choosing one primary case manager, ask the client to identify other case managers with whom he/she may be working, and communicate with these other case managers to cooperatively determine the role of each agency in the client's care.

4-2 COORDINATION WITH THE RYAN WHITE PART B AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Case managers should be familiar with the staff working with ADAP clients

- The AIDS Drug Assistance Program (ADAP) staffs who determines the client's eligibility for participation in the ADAP program is not a case manager but State employees in most instances. Eligibility requirements are addressed in **Section 7** of these guidelines
- The ADAP Program does not provide on-going case management support services for the client other than referral to other programs. An ADAP client, who may be in need of Medicaid programs or may be eligible for SSI disability benefits, is referred to local case management agencies for assistance in obtaining needed social service support.

4-3 COORDINATION WITH THE RYAN WHITE PART B AIDS INSURANCE CONTINUATION PROGRAM

Case managers should be familiar with the staff working with AICP clients.

The AIDS Insurance Continuation Program's (AICP) case managers are generally very specialized. They are responsible for determining client eligibility for participation in the AIDS Insurance Continuation Program and the following:

- Assisting and supporting the client with insurance related issues
- Providing continual monitoring of the client's insurance status
- Sixty-day contact requirement through phone or personal contact
- Re-evaluation annually for eligibility re-determination

Client support services are generally handled by the more "general case manager" in the respective community based organization or referred to other case management agencies.

4-4 OTHER PROGRAMS

The case manager should become familiar with the other local, state and federal programs in the service area which provide HIV/AIDS services and have case managers on staff.

Standard 18: Case management agencies (case managers) must coordinate their efforts with other case managers and programs providing case management services so that direct service delivery is as seamless and unobtrusive as possible to the client.

SECTION 5: MANAGING CASELOADS

This section provides the guidelines for managing a caseload according to the designations New, Active, Inactive and Closed files and according to the needs of the clients. It is the activity level of a caseload which determines a case manager's workload, not the number of cases. As the needs of the client change, the manner in which the case manager manages their caseload must change. Case managers with appropriate supervisory oversight are responsible for maintaining caseloads according to the following guidelines.

5-1 CASELOAD REVIEW OR CATEGORIZING

Each case manager must organize their caseloads using the following method.

The Guidelines

1. Each case manager must review and categorize their files as New, Active, Inactive and Closed using the following factors:

New Cases:

- The case is less than one month old
- The case is a transfer from another case management agency
- The client has completed the eligibility determination process

Active Cases:

- A case a month or older in which there has been contact within the last 6 months (180 days)
- An established client in which there is ongoing contact with the case management agency

Inactive Cases Include:

- The client has had no contact with the case management agency for at least 6 months (180 days)
- The client is temporarily institutionalized in one of the following settings:
 - Local or County Jail
 - Nursing Home
 - Hospital Extended Care Facility
- The file is transferred to another case management agency but held in an inactive status for 90 days. When the client does not transfer back within 3 months the file is moved to

Closed status

- A client's services have been temporarily suspended due to non-compliance with stated Rights and Responsibilities

Closed Cases:

A case is closed with the supervisor's agreement and a final discharge/termination narrative included in the file. Cases are closed under the following circumstances:

- The client is deceased
 - The client has requested closure
 - The client has requested no case management services
 - The client has transferred to another case management agency
 - The client has been incarcerated in a State or Federal prison
 - The client has been enrolled in Medicaid (PAC; MediPass; Medicaid; HMO)
 - The case management agency has not had contact for 12 months or more
2. Determine and document the caseload count based on New, Active and Inactive. Not counted in the caseload are the closed cases and cases in the intake/eligibility determination process. There may be other circumstances in which cases are not counted.

5-2 DETERMINING CLIENT LEVEL OF NEED

Determining the client's level of need for case management services allows the case manager to assess their caseloads and determine which clients may require more case management time and effort. Professional judgment must dictate the number and type of contacts to meet the client's needs but the following are the minimum guidelines based on the client's status as New, Active, Inactive or Closed.

The Guidelines:

- 1 Each New, Active and Inactive Case on a case manager's caseload is reviewed and evaluated by each case manager using the following acuity guidelines to estimate the level of case management activities and services.

Minimal Intervention:

- Asymptomatic
- Adherent with medication
- Adherent with appointments
- Medical needs are stabilized

- ADAP or AICP clients

Estimated 1-3 contacts within a 3-month period.

Moderate Intervention:

- The client is in need of moderate, ongoing case management services
- Infrequent adherence issues with medications
- Infrequent adherence issues with appointments

Estimated 4-10 contacts within a 3-month period.

Intense Intervention:

- All new cases for the first month
- Symptomatic
- Clients have medical or personal crisis
- Clients with serious substance abuse or mental health issues

Estimated 11-20 contacts within a 3-month period.

5-3 OPTIMAL CASELOADS

When caseloads increase above 5 New / 40 Active / 10 Inactive, the case manager must advise the case manager supervisor. An evaluation of the caseload by the supervisor is warranted.

Standard 19: Case manager must review, determine and document caseload size according to the status of the case and the activity level of the clients need and update every 6 months.

SECTION 6: ALLOWABLE ACTIVITIES AND OTHER REQUIREMENTS

This section lists the allowable services provided by the HIV/AIDS patient care programs administered by the Department. The definition and the limitations have been provided and all of the services are based on availability of services and funds. It should be noted this list is intended to provide aid in defining those services allowed, but the availability and accessibility for clients may vary locally. The most current federal Glossary of Services should always be used with this information. (Refer to Health Resources and Services Administration for details).

CORE SERVICES

6-1 AMBULATORY OUTPATIENT/MEDICAL CARE:

Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing; early intervention and risk assessment; preventive care and screening; practitioner examination; medical history taking; diagnosis and treatment of common physical and mental conditions; prescribing and managing medication therapy; care of minor injuries; education and counseling on health and nutritional issues; minor surgery and assisting at surgery; well-baby care; continuing care and management of chronic conditions; and referral to and provision of specialty care. Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

- Includes clinical services involved in expanded access or compassionate use programs where efficacy data exist and where the FDA has authorized such expanded use
- Includes laboratory or other diagnostic and monitoring tests and procedures such as radiographs, blood counts, or viral load testing
- Includes the payment of co-payments or deductibles for health insurance, Medicaid or Medicare programs
- Does not include services such as clinical services, administrative management or medical monitoring of patients used in operating clinical trials of investigation agents or treatments.

6-2 DRUG REIMBURSEMENT PROGRAM:

Ongoing service/program to pay for approved pharmaceuticals and/or medications for persons with no other payment source. Subcategories include:

- a. State-Administered AIDS Drug Assistance Program (ADAP): Part B funded and administered program or other state-funded Drug Reimbursement Program, or
- b. Local/Drug Reimbursement Program: A program established, operated, and funded locally by a Part A TGA to expand the number of covered medications available to low-income patients to broaden eligibility beyond that established by a state-operated Part B or other state-funded Drug

Reimbursement Program.

Medications include prescription drugs provided through an AIDS Drug Assistance Program to prolong life or prevent the deterioration of health.

- Does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit
- Does not include the purchase of pharmaceuticals in clinical trials, expanded access or compassionate use programs
- Does not include the purchase of therapeutic drugs that are NOT FDA-approved or the ancillary devices (e.g., IV tubing, nebulizers, etc.) needed to administer these therapeutics
- Does not include laboratory or other diagnostic and monitoring test and procedures such as radiographs, blood counts, or viral load testing

6-3 HEALTH INSURANCE:

A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools.

- May include payment of public or private health insurance co-payments and deductibles for low-income individuals only. Low-income is to be locally defined
- May include payment of premium for a family health insurance policy to ensure continuity of insurance coverage for a low-income HIV+ family member, even when some members of the covered family are not HIV+
- No direct cash payments may be paid out using Ryan White funds

6-4 HOME HEALTH CARE:

Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services include:

- Durable medical equipment
- Homemaker or home health aide services and personal care services
- Day treatment or other partial hospitalization services
- Intravenous and aerosolized drug therapy, including related prescription drugs
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental, and rehabilitation services
- Home-and community-based care does not include inpatient hospital services or nursing home and other long-term care facilities
- May or may not include Pastoral Counseling for eligible individuals
- Includes consumable medical supplies (medically necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the client's home)
- Durable Medical Equipment (DME) is defined as medically necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the client's home

May include the purchase of water filtration/purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) in communities where recurrent problems with water purity exist. Such devices (including their replacement filter cartridges) purchased with CARE Act funds must meet the National Sanitation Foundation standards for absolute cyst removal of particles less than one micron. The purchase of permanent systems for the filtration of all water entering a private residence is NOT PERMITTED.

- May include devices necessary for the delivery of FDA-approved medications
- May include clinician prescribed Developmental Services for HIV+ infants/children when such services are not covered by specific State and Federal legislation that mandate health care coverage for all children with developmental disabilities
- May include caregiver training for in-home medical or support services

6-5 ORAL HEALTH (DENTAL CARE):

Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

6-6 HOSPICE SERVICES

- a. Home-Based Hospice Care: Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting
- b. Residential Hospice Care: Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients
 - May include Pastoral Counseling for eligible individuals
 - A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less

6-7 MENTAL HEALTH SERVICES (THERAPY/COUNSELING):

Psychological and psychiatric treatment and counseling services, including individual and group counseling provided by a mental health professional licensed or authorized within the state, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors. Includes support groups and counseling services for individuals who are not infected with HIV when the primary purpose for the service is enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS or to help infected family members manage the stress and loss associated with HIV.

6-8 NUTRITIONAL COUNSELING:

Provision of nutrition education and/or counseling. Must be provided by a licensed/registered dietitian or nutritionist.

6-9 REHABILITATION SERVICES:

Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.

6-10 SUBSTANCE ABUSE SERVICES (TREATMENT/COUNSELING):

Treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

- Pre-treatment program of recovery readiness
- Harm reduction
- Mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Methadone treatment
- May include neuro-psychiatric pharmaceuticals
- May include relapse prevention
- Does not include services related to syringe exchange programs. May include detoxification if provided in a non-hospital, separately licensed setting or a separately licensed detoxification facility within the walls of a hospital
- If the treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose

6-11 HIV/AIDS TREATMENT ADHERENCE SERVICES:

Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments. Case management agencies should become familiar with medication adherence programs in their area for referral purposes. Case managers should support the adherence program's efforts to educate the client about the importance of adherence to medication and the consequences. Case management agencies should also become familiar with the "No Show" problem at the local clinics and coordinate with the medical care providers to ensure client adherence to medical appointments. Case managers should be familiar with their client's schedules and assist in the removal of barriers which keep clients from their appointments.

6-12 MEDICAL CASE MANAGEMENT:

A range of client-centered services that links clients with health care, psychosocial and other services to ensure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive,

individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client: may include client-specific advocacy and/or review of utilization of services.

- Case management services for the purpose of assisting CARE Act-eligible clients to secure access to other public and private programs for which they may be eligible. Includes services to ensure that the utilization of other funding sources is aggressively and consistently pursued
- May include services for clients who are incarcerated when the purpose of the service is to pursue continuity of care and facilitate the continuation of services upon discharge from a facility
- Does not include any case management services related to arranging or helping to arrange for funeral, burial, cremation or related services

SUPPORT SERVICES

6-13 PSYCHOSOCIAL SUPPORT SERVICES (COUNSELING):

Individual and/or group counseling other than mental health counseling provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education. May include Pastoral Counseling if provided by institutional pastoral care programs (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers; or components of a larger service, such as home care or hospice care. If provided, Pastoral Counseling must be available to all individuals eligible for CARE Act services regardless of the religious or denominational affiliation.

6-14 DAY OR RESPITE CARE:

Home-or community-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child.

- May include services of a licensed or registered child care provider for intermittent or continuing care of HIV+ children or adults
- May include services to enable an infected adult or child to secure needed medical or support services
- May include the services of a registered provider for child care to infected or non-infected children
- May include services for informal child or adult day care provided by a neighbor, family member, or other person (with the understanding that giving cash to individuals to pay for these services is prohibited)
- May include child or adult day care to support the participation of CARE Act eligible persons in clinical trials, expanded access or compassionate use programs
- May include periodic and time-limited respite for the caregiver(s) of infected adults or children which is necessary to support the caregiver in continuing those responsibilities
- Does not include off premises social or recreational activities

6-15 EARLY INTERVENTION SERVICES:

Counseling, testing, and referral services to PLWH who know their status but are not in primary medical care or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

6-16 EMERGENCY FINANCIAL ASSISTANCE:

Provision of short-term payments for transportation, food, essential utilities, or medication assistance.

- May include vouchers for food, transportation, housing, or medication assistance
- Emergency services must be for limited amounts, limited use and for limited periods of time

6-17 FOOD BANK/HOME DELIVERED MEALS/NUTRITIONAL SUPPLEMENTS:

Provision of food, meals, or nutritional supplements.

- Does not include assistance with purchasing non-food products provided to eligible individuals through food and commodity distribution programs
- Does not include assistance in purchasing pet food or other pet maintenance products.

6-18 HEALTH EDUCATION/ RISK REDUCTION:

Provision of information, including information dissemination, about medical and psychosocial support services and counseling, or preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.

6-19 HOUSING ASSISTANCE:

This is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Short-term or emergency housing must be linked to medical and/or health care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

6-20 HOUSING RELATED SERVICES:

Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, state and federal housing programs and how they can be accessed.

- Does not include any assistance with the payment of personal property taxes

6-21 LEGAL SERVICES:

Legal services directly necessitated by a person's HIV status including: preparation of powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to eligible services (See also, Permanency Planning and Child Welfare Services).

- Does not include legal services for criminal defense or for class action suits unrelated to access to services eligible under the CARE Act
- Does not include moving or expenses

- Does not include services for the direct maintenance of a privately owned vehicle (tires, repairs, etc.)
- Does not include services that provide for the purchase of clothing
- Does not include funeral, burial, cremation or related services

6-22 OUTREACH SERVICES:

Programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Broad marketing of the availability of health care services for PLWH should be prioritized and funded as Planning Council or Consortium support activities.

- Does not include funding of broad scope awareness activities about HIV service, which target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.)

6-23 PERMANENCY PLANNING:

The provision of social service counseling or legal counsel regarding:

- Drafting of wills or delegating powers of attorney; and
- Preparation for custody options for legal dependents including standby guardianship, joint custody or adoption

May include preparation of Powers of Attorney, Do Not Resuscitate (DNR) Orders, wills, trusts, etc.

- May include bankruptcy proceedings
- May include interventions necessary to ensure access to benefits for which an individual may be eligible, including discrimination or breach of confidentiality litigation as it relates to eligible services
- May include services to uninfected individuals when the service reasonably contributes to promoting family stability in coping with the unique challenges posed by HIV/AIDS
- Does not include legal services for criminal defense or for class action suits unrelated to access to eligible services

6-24 REFERRAL:

The act of directing a person to a service in person or through telephone, written, or other type of communication. Referral may be made formally from one clinical provider to another within a case management system by professional case managers, informally through support staff, or as part of an outreach program.

6-25 TRANSPORTATION:

Conveyance services provided to a client in order to access health care or psychosocial support services.

- May be provided routinely or on an emergency basis
- May include transportation to support the participation of eligible persons in clinical trials, expanded access or compassionate use programs
- May include mileage reimbursement to individuals for necessary travel to access medical and support services as long as the rate does not exceed the established rate for federal programs
- Transportation should be by contract with a provider of such services; voucher or token systems; use of volunteer drivers (through programs with insurance and other liability issues specifically addressed) or purchase or lease of organizational vehicles for client transportation programs
- May include transportation services for visits to physicians, laboratory, dental, diagnostic, individual counseling, support group and substance abuse providers, entitlement programs, pharmacy delivery and housing referral
- May include bus passes, taxi passes, etc.
- Does not include transportation to a parole and probation office or transportation to a client's work site
- Does not include transportation to recreational or entertainment events

OTHER SUPPORT SERVICES

Direct support services not listed above, such as translation/interpretation services.

6-26 PROGRAM SUPPORT:

Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service delivery patterns.

Standard 20: Case managers must be familiar and have accessibility to updated information relating to allowable services and limitations.

SECTION 7: REFERRALS AND OTHER PROGRAMS

This section provides a summary of some state and federal programs which may be available to individuals if eligibility requirements are met. There are numerous other programs which case managers should be familiar to provide appropriate referral information. The local offices should be contacted for current contact information.

7-1 ELIGIBILITY REQUIREMENTS FOR THE AIDS DRUG ASSISTANCE PROGRAM

To be eligible for participation in the Ryan White Part B AIDS Drug Assistance Program, a person with HIV/AIDS must meet at least the following eligibility requirements with the appropriate documentation:

- Proof of being positive
- Confirmed to have income less than 300% of the federal poverty level
- Lack of health insurance must be established
- Must be living in Charlotte-Gastonia-Concord-Rock Hill, SC TGA at the time of application

Only qualified and specifically trained staff can determine eligibility for the AIDS Drug Assistance Program. Contact the local County Health Department for more information regarding the complete eligibility requirements and enrollment into the ADAP program.

7-2 ELIGIBILITY REQUIREMENTS FOR THE AIDS INSURANCE CONTINUATION PROGRAM (AICP)

To be eligible for participation in the Ryan White Part B AIDS Insurance Continuation Program, a person with HIV/AIDS must at least meet the following eligibility requirements with the appropriate documentation:

- Diagnosis of AIDS, or HIV positive with at least one symptom since tested positive
- Gross income less than or equal to 300% of Federal Poverty Level (FPL) guidelines
- Cash assets less than or equal to \$4,500 for one person, \$5,500 for more than one person
- Currently covered by private health insurance
- Willing to sign all forms and provide eligibility information

Only qualified and specifically trained staff can determine eligibility.

7-3 ELIGIBILITY DETERMINATION FOR NORTH CAROLINA MEDICAID PROGRAMS

North Carolina's Medicaid Program is a federal/state program administered by the Division of Medical Assistance (DMA) The program provides medical insurance and services to indigent individuals who meet

eligibility requirements. Eligibility determination is made by the Department of Social Services and the requirements include but are not limited to:

- U.S. citizens
- Disabled adults aged 18 - 65
- Gross income of \$530 per month or less (\$796 for couples)
- Have countable resources not greater than \$2,000 (\$3,000 for couples)
- Have a Social Security number

Contact the local Department of Children and Families, Office of Economic Self Sufficiency for the complete eligibility requirements and program services.

In addition to the regular Medicaid health insurance program for adults, Mecklenburg County has four low cost or free health insurance programs for kids:

KidCare Medicaid - An entitlement program for kids ages 0 -18 years whose family income is 100% or less of the Federal Poverty Guidelines. No co-payments or premiums apply

MediKids - A non-entitlement program for kids' ages 1-4 years whose family income is 200% of the Federal Poverty Guidelines. Monthly premiums apply

North Carolina Healthy Kids - A public/private partnership program for kids ages 5 -18 years through commercially licensed insurers. Limited enrollment, premiums and co-payments apply

Children's Medical Services Network - A care network for kids' ages 0-19 years who have special, ongoing health care needs such as leukemia or diabetes, and behavioral health problems. There are no co-payments but premiums usually apply

Contact the local Department of Children and Families, Office of Economic Self Sufficiency for the complete eligibility requirements and program services.

7-4 ELIGIBILITY DETERMINATION FOR THE STATE HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) PROGRAM

The eligibility requirements for the State Housing Opportunities for Persons with AIDS (HOPWA) include but are not limited to:

- Must be enrolled through the Regional HIV/AIDS Consortium
- Must have an HIV positive antibody test as stated in Section 4-4
- Must have a documented income that does not exceed 80% of the median income for the area as referenced in Section 4-4
- Must have a documented HIV-related need for housing assistance as referenced in HOPWA Guidelines.

The required documentation to determine HOPWA income eligibility includes but is not limited to all sources of income and the amount received per month. Contact the appropriate HOPWA Project Sponsor for complete eligibility, documentation and program services.

7-5 ELIGIBILITY DETERMINATION FOR THE North Carolina DEPARTMENT OF CORRECTIONS - HIV PRE-RELEASE PROGRAMS FOR INMATES

The statewide HIV Pre Release Planning Projects are Department of Corrections programs administered by the Department of Health, Bureau of HIV/AIDS and are designed to link HIV positive inmates with medical care, medications, and necessary support services immediately after release.

The eligibility requirements for participation in the Pre-Release Programs for Inmates include but are not limited to:

- Inmates within the Mecklenburg County prison system with HIV disease
- Eligibility requirements as established in these Guidelines.

7-6 ELIGIBILITY DETERMINATION FOR SUPPLEMENTAL SECURITY INCOME (SSI), DISABILITY AND MEDICALLY NEEDY

SSI, Disability and Medically Needy are federal programs that provide supplementary medical insurance to indigent or disabled U.S. citizens and legal aliens. The eligibility requirements for Supplemental Security Income (SSI) and Disability are more restrictive than the requirements for the Medically Needy programs. Eligibility is determined by the Federal Social Security Administration and the Department of Children and Families. Program requirements include but are not limited to:

- U.S. citizens or legal aliens
- Disabled adults aged 18 -65
- Adults aged 65 or older
- Have gross incomes of \$530 per month or less (\$796 for couples)
- Have countable resources not greater than \$2,000 (\$3,000 for couples)
- Have a Social Security number

Contact the local Department of Children and Families, Office of Economic Self Sufficiency for the complete eligibility requirements and program services.

7-7 ELIGIBILITY DETERMINATION FOR THE VETERANS ADMINISTRATION

Veterans with HIV may be eligible for services through the United States Veterans Administration (VA). The VA provides healthcare and pensions to all men and women discharged from active military service under other than dishonorable conditions. Veterans in prison and parolees may be eligible for certain VA benefits. To determine eligibility, a veteran must:

- Submit a copy of their service discharge, DD-214 or give their full name, military service number, branch of service, and dates of service.

Veterans are asked to show all sources of annual income and net worth in order to determine their medical

co-pay amounts. Contact the local Veterans Administration Office for the most current information and pamphlets.

7-8 ELIGIBILITY DETERMINATION FOR THE TARGETED OUTREACH FOR PREGNANT WOMEN ACT PROGRAM (TOPWA)

The TOPWA program links at risk pregnant woman into prenatal care and or other required services. The eligibility requirements for the TOPWA Program include but are not limited to:

- Pregnant women
- Are not receiving adequate prenatal care
- At risk for giving birth to HIV Infected substance exposed Infant

Contact the local TOPWA Provider for additional eligibility information and pamphlets.

7-9 ELIGIBILITY DETERMINATION FOR WIC NUTRITION SERVICES

The eligibility requirements for women (and/or their children) for the WIC Program include but are not limited to:

- Are pregnant, postpartum, or breastfeeding if the child is under age 5 years
- Have a total household income of <185% of the Federal Poverty Guidelines
- Are North Carolina residents or receive healthcare in North Carolina
- Have proof of identification
- Are physically present at the certification visit
- Are at nutritional risk

*Women currently receiving Medicaid, Food Stamps or Work First Family Assistance are automatically eligible for WIC.

7-10 TEMPORARY CASH ASSISTANCE (TCA)

The TCA program provides cash assistance to families with children under the age of 18 or under age 19, if full-time students, that meet the technical, income and asset requirements of the program. Participants are required to perform work activities while receiving assistance and are limited to a lifetime cumulative of 48 months of assistance as an adult.

The eligibility requirements for participants include but are not limited to:

- N.C. residents and U.S. citizens
- Children under age 5 must have current immunizations
- Children must be under age 18
- All participants must have a Social Security number

- Asset limit of \$2,000 per family
- Vehicle value limit of \$8,500
- Children must be living in the home with a parent or blood relative

7-11 TANF-TEMPORARY ASSISTANCE TO NEEDY FAMILIES PROGRAM

The TANF program was created by the Welfare Reform Law of 1996 and replaced what was then commonly known as welfare: Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBSS) programs.

TANF provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs. The Department of Health and Human Services, Administration for Children and Families oversees the TANF program in every state.

7-12 WAGES -WORK AND GAIN ECONOMIC SELF-SUFFICIENCY ACT

The Department of Children and Families oversees the WAGES program in an attempt to assist low income individuals with obtaining basic necessities such as food, housing, and medical care for themselves and their families. Clients include adults with dependent children who qualify for monthly cash assistance, disabled persons; elderly persons qualifying for long-term cash assistance under the U.S. Social Security Act, and individuals who do not qualify for cash assistance but do qualify for food stamps or health care assistance through the Medicaid program.

Standard 21: Case manager must be familiar with and have accessibility to updated information relating to local, state and federal programs which may be available for clients in their service area.

ATTACHMENTS

SECTION I: ADMINISTRATIVE GUIDELINES

- A.** Confidentiality and Security Statement of Understanding
- B.** Consent for Release of Medical information
- C.** Client Consent to FAX Confidential information
- D.** Consent for Inspection and/or Release of Confidential information (Dept. of Correction)
- E.** Client's Rights and Responsibilities

SECTION 2: INTAKE AND ELIGIBILITY DETERMINATION

- F.** Intake/Eligibility Form (a-f) (Required)
 - (1)** Personal/Contact Information
 - (2)** Proof of HIV Status
 - (3)** Screening for Medicaid and other Programs
 - (4)** Client Financial Assessment
 - (5)** North Carolina Resident
 - (6)** Willingness to Sign

SECTION 3: CASE MANAGEMENT KEY ACTIVITIES

- G.** Comprehensive Assessment and Re-Assessment Worksheet (Required)
 - (1)** Eligibility and Participation in Other HIV/AIDS Programs/Services
 - (2)** Financial information
 - (3)** Medical History and Current Health Status
 - (4)** Client Adherence to Treatment
 - (5)** Social information
 - (6)** Emotional/Mental Health Status
- H.** Individualized Client Service Plan (Required Format)
- I.** Individualized Client Service Plan Revision (Required Format)
- J.** Client Discharge Summary (Sample)

SECTION 1

ATTACHMENTS



State of North Carolina

Mecklenburg County Department of Health

Confidentiality and Security Statement of Understanding

SECTION A Employee/Volunteer and supervisor must address each item with an initial.

Security and Confidentiality Supportive Data

Emp	Supv	
___	___	I have been advised of the location of and have the Mecklenburg County statutes and Administrative Rules.
___	___	I have been advised of the location of and have access to the core Department of Health Policies, Protocols and Procedures.
___	___	I have been advised of the location of and have access to the supplemental operating procedures.

Position Related Security and Confidentiality Responsibilities

___	___	I have been given copies of the following specific North Carolina Statutes and Administrative Rules that pertain to my position responsibilities:
-----	-----	---

___	___	I have been given copies of the following specific core Department of Health Policies, Protocols and Procedures that pertain to my position responsibilities:
-----	-----	---

___	___	I have been given copies of the location of the following specific supplemental operating procedures that pertain my position responsibilities:
-----	-----	---

___	___	I have received instructions for maintaining the physical security and protection of confidential information, this is in place my immediate work environment.
-----	-----	--

___	___	I have been given access to the following sets confidential information:
-----	-----	--

Penalties for Non Compliance

___	___	I have received the Department of Health Handbook and understand the disciplinary actions associated with a breach of confidentiality.
-----	-----	--

___	___	I understand that a security violation may result in criminal prosecution and disciplinary action ranging from reprimand to dismissal.
-----	-----	--

___	___	I understand my professional responsibility and procedures to report suspected or known security breaches.
-----	-----	--

The purpose of this statement of understanding is to emphasize that access to all confidential information regarding an employee or held in client health records is limited and governed by federal and state laws. Information, which is confidential, includes the client's name, social security number, address, medical, social and financial data and services received. Data collection by interview, observation or review of documents must be in a setting that protects client's privacy. Information discussed by health team members must be held in strict confidence, must be limited to information related to the provision of care to the client, and must not be discussed outside the department.

Employee/Volunteer

Date

Supervisor Signature

Date

SECTION B Information Resource Management (Initial each item, which applies)

Employee/Volunteer has access to computer related media

____ Yes. Have employee/volunteer read and sign section B

____ No. It is not necessary to complete section B

Understanding of Computer Related Crimes act, if applicable.

The Department of Health has authorized you to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department's disciplinary standards and in addition to departmental discipline; the commission of computer crimes may result in felony criminal charges. The North Carolina Computer Crimes Act, Ch. 815, F.S., addresses the unauthorized modification, destruction, disclosure or taking of information resources.

I have read the above statements and by my signature acknowledge that I have read and been given a copy of the Computer Related Crimes Act Ch. 815, F.S. understand that a security violation may result in criminal prosecution according to the provisions of Ch.815, F.S., and may also result in disciplinary action against me according to Department of Health Policy.

The minimum information resource management requirements are:

Personal passwords are not to be disclosed. There may be supplemental operating procedures that permit shared access to electronic mail for the purpose of ensuring day-to-day operations of the department.

Information, both paper-based and electronic-based, is not to be obtained for my own or another person's personal use.

Department of Health data, information, and technology resources shall be used for official state business purposes only.

Only approved software shall be installed on Department of Health computers. (IRM Policy N0.50-7)

Access to and use of Internet from a Department of Health computer shall be limited to official state business purposes only.

Copyright law prohibits the unauthorized use of duplication of software.

Employee/Volunteer Signature

Date

Supervisor Signature

Date

Employee Print Name

Supervisor Print Name



Client Name: _____

ID#: _____

DOB: _____

BEFORE SIGNING, CROSS OUT ANY PART(S) THAT DO[ES] NOT APPLY.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

North Carolina law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. The authorizations you sign on this page will remain in effect until you request in writing that your authorizations be withdrawn, which you may do at any time. You have a right to receive a copy of all parts of this authorization upon your request.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PART I-Third Party Payers:

I, _____ do hereby authorize _____
(Name of client/legal representative) (Agency or Individual in possession of the record)

(Address [City/State/Zip] of Agency or Individual)

and any physician or health care provider examining or treating me to release to any third party payer, any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, adult or child abuse, or case management information, including any information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This includes any and all information pertaining to payment.

PART II- Other Medical Release:

I, _____ authorize _____
(Name of the client/legal representative) (Agency or Individual in possession of the record)

to release (initial by [a., b., c., d., e., f., g., h., i.,] any or all which apply):

_____ a. The general medical record created at the county health department

_____ b. The following information from the medical case management record:

_____ c. Records obtained from the following providers:

_____ d. STD records _____ e. TB records _____ f. HIV/AIDS records _____ g. Drug/Alcohol treatment records

_____ h. Psychiatric/psychological information/records _____ i. Adult and child abuse information

to: _____

For the purpose of: _____

PART III-Medicare Patient Certification Authorization to Release and Payment Request:

I, _____, certify that the information given by me in applying for payment under Title
(Name of client/legal representative)
XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers. Information needed for this or a related Medicare claim may be released. I request that payment of authorized benefits be made on behalf. I assign the benefits payable for physician's services to _____ and authorize it to submit a claim to Medicare for payment on my behalf.

PART IV- Assignment of Benefits:

I, _____ hereby assign to _____
(Name of client/legal representative)
all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges as set forth by the _____. All payments under this paragraph are to be made to _____.

I am personally responsible for charges not covered by this assignment.

_____ Date (mm/dd/yy)	_____ Signature of Client or Legal Representative
_____ Witness	_____ Legal Representative's Relationship to Client

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ Date consent revoked	_____ Signature of client or Legal Representative
_____ Witness	_____ Legal Representative's Relationship to Client



CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

North Carolina law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. You must give specific written authorization to release certain types of sensitive medical information. The North Carolina Department of Health may fax confidential medical information to a provider or receive faxed information that was requested from a provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives safely, but faxes can be misdirected.

I, _____, do hereby authorize: _____
(Name of client/legal representative) (Agency or Individual in possession of the record)

Address (street, city, state) of agency/individual with record

to fax the following information: (initial by any or all that apply)

_____ a. STD records	_____ e. TB records
_____ b. HIV/AIDS records	_____ f. Adult and child abuse information
_____ c. Drug/alcohol treatment records	_____ g. Other (specify) _____
_____ d. Psychiatric/psychological information/records	_____

This information will be faxed to:

Provider Name (fax recipient)	_____
Contact Person	_____
Provider Phone Number	_____
Provider Fax Number	_____

Signature of Client or Legal Representative

Date

Witness

Legal Representative's Relationship to the Client

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

Date Consent Revoked

Signature of Client or Legal Representative

Witness

Legal Representative's Relationship to Client



Client Name: _____
ID Number: _____
Date of Birth: _____

RELEASE OF MEDICAL INFORMATION

In addition to the state and federal statutes that require informed consent prior to release of medical information, Department of Health Security Protocols 7.1 V., D. and 16.V. F. require a specific written consent to be signed by the client prior to faxing any of that client's confidential HIV/AIDS, STD or TB information. This form is to be used when a client is requesting that you fax his/her information to a provider or receive his/her information from a provider by fax. This form does not replace the client's consent to release confidential information form (DH 3111) but should be utilized in conjunction with the DH 3111 for medical records information, or without the DH 3111 when faxing confidential information that is not part of the medical record (i.e., initial test results). Anonymous HIV test results can be received by fax from the laboratory **only if** the client presents the blue copy of the Test Request Form (DH 1628) at the time of request.

Instructions for Completion of Consent to Fax

1. Every client requesting that confidential information, as described be sent or received by fax must complete and sign this form.
2. Complete the identification information in the bottom right hand corner of the form, using the patient's name, ID and
3. Date of birth (DOB).
4. Enter the client or legal representative's name after the first I.
5. Enter the name and address of the unit of the department authorized to send or receive the faxed confidential information.
6. Check all boxes that apply to the information that will be sent or received by fax.
7. Complete the provider name, contact person, phone number, and fax number for the recipient of the faxed information. This could be a health department or non-health department provider.
8. The client or legal representative must sign and date the form. If the form is signed by the legal representative, the relationship to the client must be noted.
9. Department staff must sign as the witness to the client or representative signature.
10. If the client or legal representative chooses to withdraw the consent to fax, it must be done on the completed release form in the box provided at the bottom of the page. The client or legal representative must sign and date the form. If the form is signed by the legal representative, the relationship to the client must be noted. Department staff must sign as the witness to the client or legal representative signature. The withdraw of consent is effective upon signature.

NORTH CAROLINA DEPARTMENT OF CORRECTIONS

**CONSENT FOR INSPECTION AND/OR RELEASE OF CONFIDENTIAL
INFORMATION**

I, _____, authorize _____
(Name or general designation of program making disclosure)
to disclose to _____.
(Name of person or organization to which disclosure is to be made)

Purpose of disclosure authorized herein:

The undersigned hereby authorizes the inspection and release of copies of my medical records indicated below by the above- named health care facility/medical record custodian only to the above-named company or persons or their agents. Indicate all of the records authorized to be inspected/released by **initialing** in the appropriate space / spaces below:

- _____ A. Release of all medical records except: any information relating to HIV testing, AIDS and AIDS-related syndromes; psychiatric and psychological information; or alcohol and/or substance abuse treatment information related to my condition, and confinement (**initial appropriate box**).
- _____ B. Release of any records regarding HIV testing, AIDS and AIDS-related syndromes relating to my condition, care, and confinement (**initial appropriate box**).
- _____ C. Release of any records of psychiatric and psychological information (mental health records) relating to my condition, care and confinement (**initial appropriate box**).
- _____ D. Release of all dental records relating to my condition, care and confinement (**initial appropriate box**).
- _____ E. Release of any records regarding alcohol and/or substance abuse treatment relating to my condition, care, and confinement (**initial appropriate box**). I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 U.S.C. §290 (dd)(2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **As** to release of alcohol/substance abuse treatment records, please state the specific information to be released as provided by 42 U.S.C. §290 **Fed rule 42 CFR parts 2**:

Name of information dates of etc., if possible

(Specification of the date, event, or condition upon which this consent expires if less than six months)

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent shall be effective for 90 days unless I specify a different expiration as follows:

In furtherance of this authorization, I (we) do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized. I acknowledge the extent of my authorization of release as to the records and information denoted in paragraphs A, B, C, D and E by **initialing** the appropriate spaces above.

SIGNATURE OF PATIENT (or next of Kin, Guardian
Authorized Representative, when required)

Inmate Name _____
DC# _____
R/S _____
Date of Birth _____
SS# _____
Institution _____

STATE OF _____

COUNTY OF _____
Personally Known _____ OR Produced Identification
Type of Identification Produced _____

Sworn to (or affirmed) and subscribed before me this
day of _____, 19 _____.

Notary Public Signature

Print, type, or stamp commissioned name of Notary Public
My Commission Expires: _____ SEAL

CLIENT'S RIGHTS AND RESPONSIBILITIES

Persons eligible for the Department of Health, Bureau of HIV/AIDS have rights and responsibilities:

I. FREEDOM OF CHOICE

You have the right to choose whether or not to apply for assistance through this program

You have the right to choose the service providers from whom you will receive your services, to the extent that they are available.

You have the right to receive the services you need; these may or may not include all the services you desire.

II. RIGHT OF APPEAL

If you are denied a service you believe you are eligible to receive, you have the right to appeal the decision. You may do this by following the grievance procedures established in your respective area.

III. RESPONSIBILITIES

You are responsible for assisting your case manager in developing your Individualized Service Plan.

You are responsible for keeping scheduled appointments and accepting offered and necessary services.

You are responsible for adhering to patient care treatment, including medical provider appointments and pharmaceuticals.

You are responsible for demonstrating behavior that is cooperative, assertive, and respectful of others.

You are responsible for notifying your case manager when you have problems in obtaining services or when you are dissatisfied with your care.

You are responsible for following health care instructions to the best of your ability.

If you are designated a minimal co-payment based on the department's respective sliding fee scale you are responsible for making all co-payments as instructed prior to receiving services.

My rights and responsibilities have been explained to me and I will agree to the conditions established.

Client's/Guardian's Signature

_____/_____/_____
Date

Agency Representative Signature

_____/_____/_____
Date

SECTION 2

ATTACHMENTS

INTAKE AND ELIGIBILITY FORM

This form is used by staff (who may or may not be case managers) to obtain and document required information to determine a person's eligibility to receive HIV/AIDS medical and support services under the Mecklenburg County Transitional Grant Area (TGA).

Date of Initial Contact: / /		Date Intake/Eligibility Initiated: / /	
_____		_____	
Case Manager Signature		Date Intake Completed	
a. Personal/Contact Information			
NAME		Soc.Sec.No.	
Address		City/Township	
County	State	Zip Code	
Referred By		Phone	
Phone (H) ()		(W) ()	(Emg) ()
Date of Birth	Sex: Male Female	Race	Language
Client Preference for Contact (circle)	Phone	Message	Office Visit Home
Can talk to: 1. _____ 2. _____			
Is it O.K. to include HIV/AIDS info in day phone contact?		Y N	
Is it O.K. to include HIV/AIDS info in evening phone contact?		Y N	
Is it O.K. to include HIV/AIDS info in mail?		Y N	
Directions to Home:			
Gender: M / F / Trans			
Ethnicity: White / African-American / Hispanic / Native American / Asian-Pacific			
Marital Status: S / M / P* / D / W		Family Size:	
Employed: Yes / No Name of Employer:			
Others Who Live with Client:	Relationship:	Aware of HIV Status:	Supportive:
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
HIV Positive? Yes / No / Ped <2 years		Date of Test: / /	Test Location:
AIDS Diagnosis? Yes / No		Date of AIDS Diagnosis: / /	CD4: Date of CD4: / /
Client Statement of Needs:			

*Partner

b.***HIV Status***

Current laboratory documentation, specifically viral load tests, must also be provided whether the physician is public or private. A current lab report must be less than 6 months old. Viral load levels must be less than four months old. (Complete only applicable information.)

Last Name		First Name	
HIV Diagnosis? Yes / No	Date of HIV Diagnosis ____/____/____	CD4: _____	Date ____/____/____
Location of HIV Diagnosis: _____			
City	County	State	
Awaiting Results Test Date: ____/____/____	HIV+ Asymptomatic Test Date: ____/____/____	HIV+ Symptomatic DX Date: ____/____/____	AIDS DX Date: ____/____/____
AIDS Diagnosis? Yes / No	Date of HIV Diagnosis ____/____/____	CD4: _____	Date ____/____/____
Location of AIDS Diagnosis: _____			
City	County	State	
Verification (check one)			
<input type="checkbox"/> A confirmed positive HIV antibody test, <input type="checkbox"/> A positive HIV direct viral tests such as PCR or P24 antigen, <input type="checkbox"/> A positive viral culture results, <input type="checkbox"/> Detectable HIV viral load and viral resistance test			
Contact information for agency holding proof of positivity for this person/client			
____ () _____			
Agency Name	Address	Phone Number	Extension
Check All Documentation That Applies: Viral Load _____ ELISA w/Western Blot Confirm _____			
Anonymous: _____ Confidential: _____ If confirmed by other than person completing this form, list name and title here: _____			
Complications:		CD4:	
Current or most recent Physician(s):		Phone:	
Address:			
Verification (circle one)		Received/Obtain From:	
Source: Name		Agency	
Address			
City		State	Zip

Attach results.

c. Screening for Medicaid and Other Programs

1. Indicate the results of the Medicaid Management Information System (MEDIFAX) for ____.

Eligible Y/N Date / /	Approved Y/N Date / / Manager	Authorization Number	Name of Case
Medicaid Cap C Program			
Medicaid Cap DA Program			
Medicare			
Dually Eligible for Medicaid and Medicare			
Medicaid HMO			

2. Indicate Other Program Participation.

Eligible Y/N	Enrolled Manager Y/N	Name of Case
ADAP - AIDS Drug Assistance Programs		
AICP - AIDS Insurance Continuation Program		
North Carolina Health Choice for Children		
WIC – Women, Infants and Children and Nutrition Services		
HOPWA – Housing Opportunities for People With AIDS		
Local Indigent Programs		
Department of Social Services - Emergency Assistance Program		
Veterans Administration		
Department of Social Services Food Stamps		
Subsidized Child Care		
Employment Securities Commission		
Other		

--

3. Insurance Information

Yes No

Do you have any other health insurance?	<i>If no, skip to next section</i>
Is your health insurance through your current or previous employer?	
If through your previous employer, DATE Cobra coverage began: / /	
Name of Insurance Company:	
Address:	
Phone: ()	
Group #:	Policy #:

d. Client Financial Assessment

Y/N	Income	Amount	Notes
	Unemployed		How Long:
	Wages or Salary:		Name of Employer: Address:
	Tips		
	Self-Employment:		Name of Employer: Address:
	Social Security Benefits		
	Temporary Assistance to Needy Families Program		
	Worker's Compensation		
	Unemployment Compensation		
	Other insurance benefits		
	Trust Fund		
	Retirement Benefits		
	Assistance given by relative and/or friends		
	Income from rental of personal property		
	Other monthly assistance from welfare agencies, public or private		
	Child Support and/or Alimony received		
	Total Annual Income	(A)	

1. Name and amount of income for all adult family members 18 and over

<i>Name</i>	<i>Relationship</i>	<i>Amount of Income</i>
	Total Annual Income	(B)

Add + =
 A B Total Income

Determine a client's family size and gross family income on the Federal Poverty Guidelines and locate the poverty level percent that corresponds to the client's gross income and family size on the Federal Poverty Guidelines.

 Percentage

Percentage is 200% or below the Federal Poverty Guidelines: Y N

2. Check which documentation provides proof of income and attach copies to this form:

Type of Income	Documentation
Employment Income	<input type="checkbox"/> Pay check stub for the past month, <input type="checkbox"/> Signed employer statements with dates, <input type="checkbox"/> Position and phone number or income, <input type="checkbox"/> Tax return
Child Support Payments	<input type="checkbox"/> Court Order/Copy of Check
Social Security (SSDI, OASDI)	<input type="checkbox"/> Social Security Award Letters
Supplemental Security Income (SSI)	<input type="checkbox"/> Statement/Award Letter
VA Benefits	<input type="checkbox"/> Statement/Award Letter
Retirement Benefits	<input type="checkbox"/> Award Letter/Copy Check
Interest income or other investment income	<input type="checkbox"/> Bank Statements
Other Cash Support	<input type="checkbox"/> Family and Friends <input type="checkbox"/> Other Appropriate and Related
Other	

3. Cash Assets Expenses (per month)

For Information

Cash on Hand	\$	Mortgage/Rent	
Checking Account	\$	Food	
Savings Account	\$	Utilities (gas/electric/other)	
Stocks/Bonds	\$	Phone	
Certificates	\$	Auto Loan	
Other	\$	Other Loans	
Other	\$	Credit Cards	
		Insurance: Health, Auto, Life, Other	
		Alimony/Child Support	
		Medical Expenses	
		Other	
TOTAL		TOTAL	

(File this information for future reference)

I attest that all of the information stated is accurate to the best of my knowledge:

Client Signature _____ Date _____

e. Residency

	YES	NO
The person is living in the state of North Carolina at the time of the eligibility determination:		
Client provided the following as proof: A physical living address (as well as a mailing address if the two are not the same):		
The person is a resident of North Carolina		

If no, the person was referred to _____ for additional services.		

f. Must Be Willing To Sign All Forms and Provide Eligibility Documentation

	YES	NO
The person is willing to sign all forms and provide all appropriate documentation to assist with the eligibility determination process in an expeditious manner.		

Eligible _____ Y _____ N

If yes, is consumer referred to case management on this date _____.

If no, is consumer provided a written explanation on this date _____?

Did consumer request access to grievance procedures ____ Y ____ N?

SECTION 3

ATTACHMENTS

RYAN WHITE PROGRAM PART A
MECKLENBURG COUNTY HEALTH DEPARTMENT
Case Management Assessment and Re-Assessment Tool

General:

Client Case #: _____

Date of Assessment:/Re-Assessment _____

Client's full name: _____

Location of Assessment: _____

Was information obtained during the assessment provided by person(s) in addition to the client? Yes ☐
No ☐

If yes who? _____

Relationship: _____

Phone: _____

Please refer to original intake and assessment for any demographic information.

Education:

Educational level: Grade School ☐ High School/GED ☐ Associates Degree ☐
Undergraduate Degree ☐ Graduate/Post Grad. Degree ☐

Reading Ability/Literacy: High ☐ Moderate ☐ Limited ☐

Race/Ethnicity:

Race: ☐ African American ☐ Latino/Hispanic
☐ Asian/Pacific Islander ☐ Native American
☐ Black/Non-Hispanic ☐ White/Non-Hispanic
☐ Other: _____

Housing:

Housing Type: Apartment/Condo ☐ House ☐ Mobile Home ☐ Hospital ☐ Group Home ☐
Group Facility ☐ Nursing Home ☐ Transitional ☐ Penal ☐
Homeless ☐ Unknown ☐

Housing Status: Rent ☐ Own ☐ Doesn't Contribute ☐ Unknown ☐

Also check one of the following: Permanent (stable) ☐ Non-Permanent ☐ Unknown ☐

Living Situation: Other Adults/Dep. Child(ren) ☐ No Other Adults/Dep. Child(ren) ☐ Alone ☐
Other Adults/ No Dep. Child(ren) ☐ Minor with Adults ☐ Other: ☐ Unknown ☐

Living Conditions: Adequate ☐ Overcrowded ☐ Criminal Activity ☐ No Indoor Plumbing ☐
Substandard ☐ Unaffordable ☐ Threat of Physical Violence ☐
Other: Unknown ☐

Date Moved In: _____

Number of Bedrooms: _____

Current Housing Programs: HOPWA ☐

Section 8 ☐

Housing Authority ☐

None ☐ Unknown ☐ Other: _____

Does the client have any physical impairments/limitations that affect his/her safety in the home?

Yes ☐ No ☐ If yes, please describe _____

Are there any structural or functional inadequacies in the client's home?

Yes ☐ No ☐ If yes, please describe _____

Make any other comments about the client's home environment you have observed that may have an effect on his/her ability to function independently _____

Are there other persons (Adults/Non-dependent Children) in the household? Yes ☐ No ☐

If yes, please note below:

Name	Relationship	DOB	May We Contact?		Aware of HIV Status?	
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Does the client have dependent children? Yes ☐ No ☐

If yes, complete the following:

Name	DOB	HIV Status	Name of School/Daycare	Grade	Contact Person	Phone Number	Aware of HIV Status?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>

Transportation:

Does client own a car? Yes ☐ No ☐ **Is this client's main access to transportation?** Yes ☐ No ☐

If no, please describe client's ability to access transportation:

Insurance:

Medicare: Yes ☐ No ☐ Medicare #: _____ Effective Date: _____

Expiration Date: _____ Date applied if pending: _____

VA Benefits: Yes ☐ No ☐

Effective Date:

Expiration Date:

Date applied if pending:

ADAP/POC: Yes ☐ No ☐

Effective Date:

Expiration Date:

Date applied if pending:

COBRA coverage: Yes ☐ No ☐

Name of Ins. Co.:

Group #

Subscriber #:

Effective Date:

Expiration Date:

Date applied if pending:

Employer:

Private Insurance: Yes ☐ No ☐

Name of Ins. Co.:

Group #

Subscriber #:

Effective Date:

Expiration Date:

Date applied if pending:

Employer: _____

Occupation: _____

Other coverage: Yes ☐ No ☐

Name of Ins. Co.:

Group #

Subscriber #:

Effective Date:

Expiration Date:

Date applied if pending:

Employer:

Occupation:

Work History:

Company Name	Type	Start date	End date	Monthly Income Before Taxes	Monthly Income After Taxes

Financial Resources:

Household Income per month (includes income of client and other household members)

Income

Expenses

Client Income Source	Status (please check one)	Amount	Source	Amount
Employment	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Rent/Mortgage	_____
SSD	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Car Payment	_____

SSI	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Transportation	_____
Food Stamps	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Credit Card/Loans	_____
TANF (formerly AFDC)	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Health Care	_____
Unemployment	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Insurance	_____
VA Benefits	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Utilities	_____
Other	(yes <input type="checkbox"/> no <input type="checkbox"/> pending <input type="checkbox"/>)	_____	Phone	_____
Total		_____	Food	_____
			Child Support	_____
Assets			Alimony	_____
Source	Amount		Entertainment	_____
Life Insurance	_____		Other	_____
Checking	_____		Total Monthly Expenses	_____
Savings	_____		Total Monthly Income	_____
Property	_____		- Total Monthly Expenses	_____
Burial Insurance	_____		Total Monthly Cash Flow	_____
Total	_____		Confirmed Zero Income	Yes <input type="checkbox"/> No <input type="checkbox"/>

Legal Issues:

Legal Documents Status: Please check as appropriate.

DOCUMENT	NEEDED		IN PROGRESS		COMPLETED		NOT NEEDED
Will	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Durable Power of Attorney	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Living Will	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Health Care Power of Attorney	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Guardianship	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Burial Plans	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>
Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>

Comments:

Legal Problems Status: Please indicate information as appropriate.

CHARGES	APPROXIMATE DATE	LOCATION (state, county)	DISPOSITION	DATES OF INCARCERATION	DATES OF PROBATION

--	--	--	--	--	--

Comments: Please remark on any pending legal problems or needs.

Health:

Primary Care Physician: _____

Phone Number: _____

Infectious Disease Physician: _____

Phone Number: _____

Medical Facility most often used: _____

Contact: _____

Phone Number: _____

Date received proof of HIV status: _____

Confirmed by: _____

Are there any known allergies (drugs, food, and animals, other)? Yes ☐ No ☐

Please list known allergies _____

Does the client have any diagnosed health problems (heart disease, TB, hepatitis, other)? Yes ☐

No ☐

Diagnosed Health Problems	Treatments	Date of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the client ever been hospitalized? Yes ☐ No ☐

If yes, please complete the following:

Date	Hospital	Length of Stay	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a history of opportunistic infections? Please check yes or no)

OI	History	Date
PCP	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
CMV Retinitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
MAI-TB	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Histoplasmosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cryptosporidium	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Kaposi Sarcoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Shingles	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Toxoplasmosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Coccidiomycosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cryptococcal Meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Pulmonary TB	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Invasive Cervical Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Other?

On PCP prophylaxis? Yes ☐
No ☐

Is there a history of other HIV
related conditions? (please check
yes or no)

Fevers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaginitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/> No <input type="checkbox"/>	PID	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chills	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thrush	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fatigue	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dysphagia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Malaise	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cold Sores	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Loss >10 lbs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Loss of Appetite	Yes <input type="checkbox"/> No <input type="checkbox"/>	Change in Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea > 1wk	Yes <input type="checkbox"/> No <input type="checkbox"/>	Periodontal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Short Term Memory Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>
Syphilis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes: please comment on these illnesses or others: _____

Describe any other health concerns not identified above: _____

Does the client have any visual or hearing impairment? _____

What affect does the client feel his/her health status has on their ability to work? _____

What does the client identify as the greatest barriers to keeping medical appointments? _____

How frequently does the client miss or reschedule medical appointments? _____

****Current Medications: Please complete the Medical Review and Medications List as part of this assessment/reassessment. Include HIV, Non-HIV, Psychotropic Medications, OTC Medications, Herbal Remedies, etc, on the list. Include the most current CD 4 and Viral Load data available.**

If taking medications how does the client feel after taking medications? _____

Does the client use a pharmacy or a mail order service to obtain medications? _____

Name of pharmacy/service and contact number (if applicable): _____

What barriers does the client identify to taking medications as prescribed? _____

Identify any past and/or current self-treatments, alternative therapies, etc., and its importance to the client.

How does the client rate his/her overall health? ☐ excellent ☐ good ☐ fair ☐ poor

How many meals does the client eat each day? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6+

Does the client seem to have a well balanced diet (fruits, vegetables, grains, proteins, dairy)? Yes ☐ No ☐

Please make any other comments you feel necessary to describe nutritional needs: _____

Dental:

Does the client receive dental care? Yes ☐ No ☐

If yes name of dentist: _____

Phone number: _____

Date of last check up: _____

List all dental/ maxiofacial problems: _____

Does the client have mouth/dental problems that affect what or how much she/he can eat: Yes ☐ No ☐

If yes, please describe: _____

ADL's/IADLs:

Describe client's ability to function independently in the following areas.

Activity of Daily Living	Does Client Need Assistance?	Type of Assistance Needed	Source of Assistance
Ability to Ambulate	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to Transfer Self	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to Feed Self	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to Toilet	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to Bathe Self	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Ability to Groom Self	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to Dress Self	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Others? _____

Instrumental Activity of Daily Living	Does the Client Need Assistance?	Type of assistance needed:	Source of assistance received:
Housecleaning	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Laundry	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Shopping	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Medication Management	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Money Management	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ability to use phone	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Others? _____

Who reported the ADL's and IADL's? _____

Recreation/Leisure:

What does the Client do for fun or stress relief? _____

Spirituality:

How does Religion play a role in the Client's life? _____

What gives the client's life purpose or meaning? What gives the client hope? _____

Substance Use:

Identify current or past use of any substances including alcohol, tobacco, prescription and OTC medications:

Substance	Age of first Use	Frequency of use over past 30 days	Average quantity of use/day	Date of last use	Currently Using?	Does client identify use as a problem
					Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

What is client's report of their withdrawal symptoms (what happens when you "come down" off drugs): _____

Assess current support system related to use: _____

Is the client willing to receive a referral to a substance use counselor? Yes ☐ No ☐

If no explain: _____

Risk:

<input type="checkbox"/> Injecting Drug User <input type="checkbox"/> Current user <input type="checkbox"/> In treatment <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Illness <input type="checkbox"/> Men who have sex with men <input type="checkbox"/> Men who have sex with men and injection drug use <input type="checkbox"/> Female/Female Sexual Contact <input type="checkbox"/> Bisexual Contact <input type="checkbox"/> Heterosexual Contact	<input type="checkbox"/> Blood Product Recipient <input type="checkbox"/> TX of hemophilia/ Coagulation disorder <input type="checkbox"/> Sexual partner of above <input type="checkbox"/> Sexual partner of prisoner <input type="checkbox"/> Exposed in healthcare Setting <input type="checkbox"/> Homeless <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> NA – Not infected <input type="checkbox"/> Other/undetermined	Risk Reduction Counseling Received <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
---	---	---

What is the client's understanding of safer practices to avoid transmission of or re-infection with HIV? _____

What is the client's use of safer practices?

What are the barriers to the client using safer practices? _____

Describe the client's past history of Sexually Transmitted Diseases (STD's): _____

Does the client believe s/he may currently have a STD? _____

Does the client need referral for STD testing and/or treatment? Yes ☐ No ☐

Does the client need safer sex and/or drug use education? Yes ☐ No ☐

Has client notified past/current partners of HIV status? Yes ☐ No ☐

If no describe what steps you took to assist client in this process (such as referral to DIS/Health Department).

Describe the client's current environmental exposure to substance use: _____

Please make any other comments you feel may impact client's efforts at risk reduction: _____

Mood/Anxiety Assessment:

Ask and record responses to the following:

In the past 6 months, has there been an event or situation that caused you to feel so frightened, anxious, or uneasy that it felt like some form of an attack or spell? Yes ☐ No ☐

If yes please describe: _____

Were you seen by a doctor? Yes ☐ No ☐

Name: _____

Phone Number: _____

In the past 6 months, has there been an event or situation that caused your heart suddenly to race, you felt faint, or you couldn't catch your breath? Yes ☐ No ☐

If yes, please describe: _____

Were you seen by a doctor? Yes ☐ No ☐

Name: _____

Phone Number: _____

Describe your sleep pattern. (Do you wake up in the middle of the night? Do you wake up early? Do you have trouble falling asleep?). Is this a “regular pattern” for you? Do you feel rested upon waking? _____

Describe your eating pattern. Are you eating more or less than “usual”? Have you had a weight gain or loss within the last couple months? How much? Was it intentional? _____

Stressors: What are the things that worry you? How long have you worried about them? What have you done in the past to help you deal with the stress? _____

History of Mental Health Issues or disorders (for at least the past 10 years). _____

Is the client willing to accept a referral or other form of assistance with mental health issues? Yes ☐ No ☐
If no explain: _____

Mental Health/Substance Abuse Treatment History:

Please list all Mental Health or Substance treatment experiences. Include type of treatment; inpatient, outpatient, day-treatment, residential (group home), and recovery support (i.e. 12 step) experiences.

Facility/Provider	Date	Type of treatment

Are you currently in treatment? Yes ☐ No ☐

If yes with whom: _____

Phone number: _____

Crisis Intervention:

In the past 4 weeks has feeling depressed, blue, sad, and hopeless often bothered you? Yes ☐ No ☐

In the past 4 weeks, have you often been bothered by a loss of pleasure or satisfaction in doing things? Yes ☐ No ☐

In the past 4 weeks, have you ever been bothered by uncontrollable feelings of anger or suspicion or by thoughts or feelings people were trying to hurt you or sabotage your efforts? Yes ☐ No ☐

In the past 4 weeks, have you heard, seen, or felt things that no one else could? Yes ☐ No ☐

If the client answers yes to any of the above questions you MUST ask and record responses to the following questions about suicide/homicide risk and be sure to include your referral documentation to a qualified MH professional:

Are you having thoughts of hurting yourself? Yes ☐ No ☐

Are you having thoughts of hurting others? Yes ☐ No ☐

If yes, whom? _____

Do you have a plan to carry out your thoughts? Yes ☐ No ☐

If yes what is the plan? _____

Do you have access to weapons or anything else to hurt yourself or others? Yes ☐ No ☐

Record specifics of what client has access to (i.e. pills, guns, knives, etc.)

_____ Do you want or intend to hurt yourself or others? Yes ☐ No ☐

Have you ever attempted to hurt or kill yourself or others in the past? Yes ☐ No ☐

If yes, describe when and how? _____

Referral made to: _____

Phone Number: _____

Appointment date given? Yes ☐ No ☐ If yes, when _____

If no, please comment: _____

Mental Condition:

Document Client's Mental Condition at time of your interview

Behavior:

Polite ☐ Cooperative ☐ Suspicious/distrustful ☐ Aggressive ☐ Hostile ☐ Agitated ☐ Nervous ☐

Withdrawn ☐ Uncooperative ☐ Resistant ☐

Speech:

Slow ☐ Rapid ☐ Pressured ☐ Loud ☐ Soft ☐ Slurred ☐ Mumbled ☐ Monotone ☐ Clear/coherent ☐

Confused ☐ Stuttering ☐ Appropriate Speed and volume ☐

Appearance:

Neat/ well groomed ☐ Unkempt/poor grooming ☐ Malodorous (bad smelling) ☐

Unusually Dressed ☐ Appears older than age ☐ Appears younger than age ☐ Not remarkable ☐

Movements:

Steady gait (good balance) ☐ Unsteady gait (poor balance) ☐ Tics (involuntary twitches) ☐ Fidgety/ agitated ☐

Smooth movements ☐ Appears stiff or uncomfortable when moves ☐

Psychomotor retardation (moves very slowly) ☐

Level of Consciousness:

Alert ☐ Drowsy ☐ Un-responsive ☐ Non-responsive ☐

Attention/Concentration:

Good Concentration/attention ☐ Easily Distracted ☐ Difficulty following interview/answering questions ☐

Unable to complete interview because of inattention ☐

Orientation:

Oriented to person ☐ Oriented to place ☐ Oriented to time ☐

Memory:

Recent and remote (long time ago) memory intact (good) ☐ Recent Memory intact ☐

Remote Memory intact ☐ Neither recent nor remote memory intact ☐

Judgment:

Clear/logical ☐ Irrational ☐ Cloudy ☐

Thoughts:

Confused/jumbled ☐ Clear/logical ☐ Suicidal thoughts ☐ Homicidal thoughts ☐

Affect (facial expression):

Expression fits mood ☐ Expression does not fit mood ☐ Flat affect (No variety of expression) ☐
Blunt affect (less variety of expression than expected) ☐ Full range of affect (full variety of expression) ☐
Who reported the Mental Health and Substance Abuse information? _____

Community Resources and Support:

What is the client's knowledge/understanding of available community resources? _____

Has the client accessed services in the past? Yes ☐ No ☐

If yes, please list agencies.

Is the client currently receiving services? Yes ☐ No ☐

If yes, please list below:

Agency	Contact Name	Contact Number	Services Received
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others: _____

Comment on the client's ability to access services

a.) On his/her own Yes ☐ No ☐

b.) With his/her existing social service support network: _____

c.)

Client's primary source of support?

Name: _____

Address: _____

Phone: _____

Primary Care Giver Now or in the Future?

Address: _____

Name: _____

Phone: _____

Service	Needs	Receives	Service	Needs	Receives
12 Step Meetings	<input type="checkbox"/>	<input type="checkbox"/>	Advanced Directives	<input type="checkbox"/>	<input type="checkbox"/>
AIDS Clinical Trials	<input type="checkbox"/>	<input type="checkbox"/>	Alternative Therapies	<input type="checkbox"/>	<input type="checkbox"/>
Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Advocacy Buddy	<input type="checkbox"/>	<input type="checkbox"/>
Budget Counseling	<input type="checkbox"/>	<input type="checkbox"/>	Burial Assistance	<input type="checkbox"/>	<input type="checkbox"/>
CAP AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Care Teams	<input type="checkbox"/>	<input type="checkbox"/>
Case Management	<input type="checkbox"/>	<input type="checkbox"/>	Child Care	<input type="checkbox"/>	<input type="checkbox"/>
Clothing	<input type="checkbox"/>	<input type="checkbox"/>	Dental Care	<input type="checkbox"/>	<input type="checkbox"/>

Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Shelter	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Support	<input type="checkbox"/>	<input type="checkbox"/>
Employment	<input type="checkbox"/>	<input type="checkbox"/>	Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Food Pantry	<input type="checkbox"/>	<input type="checkbox"/>	Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>
HIV Education	<input type="checkbox"/>	<input type="checkbox"/>	HIV Testing	<input type="checkbox"/>	<input type="checkbox"/>
Home delivered Meals	<input type="checkbox"/>	<input type="checkbox"/>	Home Health Aide	<input type="checkbox"/>	<input type="checkbox"/>
Hospice Services	<input type="checkbox"/>	<input type="checkbox"/>	In- home Chore Provider	<input type="checkbox"/>	<input type="checkbox"/>
Information and Referral	<input type="checkbox"/>	<input type="checkbox"/>	Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	Medical- HIV Specialty Care	<input type="checkbox"/>	<input type="checkbox"/>
Medical-Primary Care	<input type="checkbox"/>	<input type="checkbox"/>	Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health- Inpatient	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health- Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Supplements	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Partner Notification	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Housing	<input type="checkbox"/>	<input type="checkbox"/>
Personal Case assistance	<input type="checkbox"/>	<input type="checkbox"/>	Pharmacy Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Post Test Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Prescriptions Filled/ Medicines	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Opportunities	<input type="checkbox"/>	<input type="checkbox"/>
Reimbursement	<input type="checkbox"/>	<input type="checkbox"/>	Rent Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Representative Payee	<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Respite	<input type="checkbox"/>	<input type="checkbox"/>
Risk Reduction Counseling	<input type="checkbox"/>	<input type="checkbox"/>	Sitter Service	<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual Support	<input type="checkbox"/>	<input type="checkbox"/>	SSI/SSDI	<input type="checkbox"/>	<input type="checkbox"/>
Sub. Abuse Counseling	<input type="checkbox"/>	<input type="checkbox"/>	Support Groups	<input type="checkbox"/>	<input type="checkbox"/>
Training	<input type="checkbox"/>	<input type="checkbox"/>	Transitional Housing	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Utility Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Vocational Rehab.	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Referrals to be made:

Level Of Care: ☐ BA ☐ CM

Summary:

Summarize information gathered from Assessment in a concise coherent manner. Essentially you are identifying problems and concerns that became evident during your assessment. Please also include strengths, weaknesses that you have identified in the client.

I, _____, certify that all the information I have given is true and accurate to the best of my knowledge and belief. I agree to provide financial and other verification that may be needed to receive services.

Client (guardian) Signature_____Date:_____

*Witness Signature (if needed):_____Date:_____

Case Manager Signature_____Date:_____

*If you do not have a third party witness available, to witness marks, please write a note of explanation and get your supervisor to initial and date this form.

CLIENT INDIVIDUALIZED SERVICE PLAN

Client Name: _____

Date Assessment Completed: _____

Date Plan Begins: _____

Case Manager Assigned: _____

Case Management Agency: _____

#	Identified Service Need	Service Provider	Goals/Objectives & Desired Outcome (Action Steps)	Realistic Time Frames	Date Outcome Met	Barriers If Applicable

Client's Statement and Agreement: I have participated in the creation of this plan for my care. I understand that I have to take responsibility for MY plan in order for the plan to succeed. The case manager has explained to me what portions of the plan I am solely responsible for and those that my case manager will assist me with. I agree to follow all aspects of this plan and advise my case manager if there are significant changes in my life that makes it necessary to change my plan. I agree to stay in contact my case manager as planned.

Client's Signature: _____

Date Plan Was Implemented: _____

Case Manager's Signature: _____

Re-evaluation Date: _____

REVISED CLIENT INDIVIDUALIZED SERVICE PLAN

Client Name: _____

Date of Initial Plan: _____

Date of Revised Plan: _____

Case Manager Assigned: _____

#	Identified Service Need	Service Provider	Goals/Objectives & Desired Outcome (Action Steps)	Realistic Time Frames	Date Outcome Met	Barriers if Applicable

Client's Statement and Agreement: I have participated in the creation of this plan for my care. I understand that I have to take responsibility for MY plan in order for the plan to succeed. The case manager has explained to me what portions of this plan I am solely responsible for and those that my case manager will assist me with. I agree to follow all aspects of this plan and advise my case manager if there are significant changes in my life that makes it necessary to change my plan. I agree to stay in contact with my case manager as planned.

Case Manager's Signature: _____

Re Re-evaluation Date: _____

CLIENT DISCHARGE SUMMARY

Client _____

File# _____

REASON: **Death** **Client and/or Guardian Request** **Ineligible**

DATE OF CLOSURE: / /

Brief Narrative (services provided, service dates, objectives, services terminated):

Summarize conference with client/guardian: (if applicable)

Appeal materials provided: **YES** **NO**

Referrals made:

Individual services terminated:

Case Manager

Supervisor

Date
Record prepared for:

Transfer

Closed Files

Mailed Date:

Date